

102
HEALTH CARE REFORM

Y 4. W 36: 103-89

Health Care Reform, Serial No. 103-...

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

VOLUME X

**President's Health Care Reform Proposals:
Impact on Providers and Consumers**

OCTOBER 7, 21, 22, 26; NOVEMBER 15, 1993; FEBRUARY 1 AND 4, 1994

PART 1 OF 3

OCTOBER 7, 21, AND 22, 1993

Serial 103-89

Printed for the use of the Committee on Ways and Means



FEB 8 1994

HEALTH CARE REFORM

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

VOLUME X

President's Health Care Reform Proposals: Impact on Providers and Consumers

OCTOBER 7, 21, 22, 26; NOVEMBER 15, 1993; FEBRUARY 1 AND 4, 1994

PART 1 OF 3

OCTOBER 7, 21, AND 22, 1993

Serial 103-89

Printed for the use of the Committee on Ways and Means



U.S. GOVERNMENT PRINTING OFFICE

82-401 CC

WASHINGTON : 1994

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-046163-4

COMMITTEE ON WAYS AND MEANS

DAN ROSTENKOWSKI, Illinois, *Chairman*

SAM M. GIBBONS, Florida	BILL ARCHER, Texas
J.J. PICKLE, Texas	PHILIP M. CRANE, Illinois
CHARLES B. RANGEL, New York	BILL THOMAS, California
FORTNEY PETE STARK, California	E. CLAY SHAW, JR., Florida
ANDY JACOBS, JR., Indiana	DON SUNDQUIST, Tennessee
HAROLD E. FORD, Tennessee	NANCY L. JOHNSON, Connecticut
ROBERT T. MATSUI, California	JIM BUNNING, Kentucky
BARBARA B. KENNELLY, Connecticut	FRED GRANDY, Iowa
WILLIAM J. COYNE, Pennsylvania	AMO HOUGHTON, New York
MICHAEL A. ANDREWS, Texas	WALLY HERGER, California
SANDER M. LEVIN, Michigan	JIM MCCRERY, Louisiana
BENJAMIN L. CARDIN, Maryland	MEL HANCOCK, Missouri
JIM McDERMOTT, Washington	RICK SANTORUM, Pennsylvania
GERALD D. KLECZKA, Wisconsin	DAVE CAMP, Michigan
JOHN LEWIS, Georgia	
L.F. PAYNE, Virginia	
RICHARD E. NEAL, Massachusetts	
PETER HOAGLAND, Nebraska	
MICHAEL R. McNULTY, New York	
MIKE KOPETSKI, Oregon	
WILLIAM J. JEFFERSON, Louisiana	
BILL K. BREWSTER, Oklahoma	
MEL REYNOLDS, Illinois	

JANICE MAYS, *Chief Counsel and Staff Director*

CHARLES M. BRAIN, *Assistant Staff Director*

PHILLIP D. MOSELEY, *Minority Chief of Staff*

SUBCOMMITTEE ON HEALTH

FORTNEY PETE STARK, California, *Chairman*

SANDER M. LEVIN, Michigan	BILL THOMAS, California
BENJAMIN L. CARDIN, Maryland	NANCY L. JOHNSON, Connecticut
MICHAEL A. ANDREWS, Texas	FRED GRANDY, Iowa
JIM McDERMOTT, Washington	JIM MCCRERY, Louisiana
GERALD D. KLECZKA, Wisconsin	
JOHN LEWIS, Georgia	

CONTENTS

PRESIDENT'S HEALTH CARE REFORM PROPOSALS: IMPACT ON PROVIDERS AND CONSUMERS

	Page
Press releases announcing the hearings	2

OCTOBER 7, 1993

WITNESSES

Alliance for Managed Competition, Lawrence P. English	57
American Hospital Association, Dick Davidson	109
American Medical Association, James S. Todd, M.D.	116
American Nurses Association, Gwendolyn Johnson	140
Blue Cross and Blue Shield Association, Mary Nell Lehnhard	64
CIGNA Healthcare, Lawrence P. English	57
Group Health Association of America, Inc., Karen Ignagni	71
Health Insurance Association of America, and Lincoln National Life Insurance Co., Ian M. Rolland	78
U.S. Chamber of Commerce, William T. Archey	20
Washington Business Group on Health, Anne Marie O'Keefe	15

OCTOBER 21, 1993

WITNESSES

AIDS Action Council, Daniel T. Bross	324
American Association of Retired Persons, Judith Brown	178
Citizen Action, Richard Kirsch, Citizen Action of New York	255
Communicating for Agriculture, Jeffrey Smedsrud	292
Consumers Union, Gail Shearer	226
League of Women Voters of the United States, Becky Cain	264
March of Dimes Birth Defects Foundation, Richard A. Ehrenkranz, M.D.	317
National Committee to Preserve Social Security and Medicare, Martha McSteen	201
National Health Law Program, Inc., Stan Dorn	246
Older Women's League, Dianna M. Porter	192

IV

OCTOBER 22, 1993

WITNESSES

	Page
American Academy of Family Physicians, William H. Coleman, M.D	413
American Academy of Pediatrics, Howard A. Pearson, M.D	430
American Clinical Laboratory Association, Hope S. Foster	466
American College of Physicians, Paul F. Griner, M.D	400
American College of Surgeons, W. Gerald Austen, M.D	407
American Dental Association, Jack Harris, D.D.S	451
American Physical Therapy Association, and Burch, Rhoads & Loomis, Ernest Burch	460
California Association of Hospitals and Health Systems, C. Duane Dauner	375
National Association of Public Hospitals, Larry S. Gage	354
National Rural Health Association, Ron V. Hunter	369

**PRESIDENT'S HEALTH CARE REFORM
PROPOSALS: IMPACT ON PROVIDERS AND
CONSUMERS**

THURSDAY, OCTOBER 7, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:05 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press releases announcing the hearings follow:]

FOR IMMEDIATE RELEASE
THURSDAY, SEPTEMBER 30, 1993

PRESS RELEASE #18
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES HEARINGS
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a series of hearings on issues relating to the President's health care reform proposals.

The hearings will begin on Thursday, October 7, 1993, at 10:00 a.m. in the main Committee hearing room, 1100 Longworth House Office Building. They will continue on Tuesday, October 12, 1993, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m. Subsequent hearings will be announced at a later date.

In announcing the hearings, Chairman Stark said: "The President's health care reform plan presents a comprehensive response to the nation's most pressing problem. The plan would commit the nation to universal health coverage and to cost containment -- goals we have been seeking for many years. The President's proposals are complex, and we want to explore this plan and the alternatives to it, thoroughly, before proceeding to mark up a bill. We, therefore, expect to hold hearings to examine various aspects of the proposals throughout the fall of 1993."

Oral testimony will be heard from invited and public witnesses during the course of the Subcommittee hearings on the President's proposals.

BACKGROUND:

The first hearing, scheduled for October 7, will include testimony from representatives of affected groups, including labor unions, health care providers, and health insurers.

Testimony from Administration experts on various aspects of the President's proposals, including benefits, coverage, low-income subsidies, cost containment, governance, and Medicare proposals, will be heard by the Subcommittee at the next two hearings. The first day of Administration witnesses will be held on October 12, and the second day will be announced in a later press release.

At subsequent hearings the Subcommittee will receive testimony from Members of Congress and from representatives of other affected groups, including consumer and employer groups.

Testimony will be heard at additional hearings to focus on a series of priority health reform issues, including:

- (1) Role of State governments and the Federal Government, including the role and functions of the proposed National Health Board, the Department of Health and Human Services, and other Federal agencies;
- (2) Role and functions of the proposed health alliances;
- (3) Health cost containment, including premium caps and alternative mechanisms;
- (4) Proposed insurance reforms and their impact, risk selection, and risk adjustment;

- (5) Impact of the plan on underserved inner-city and rural areas;
- (6) Impact of the plan on low-income populations generally;
- (7) Medicare savings proposals;
- (8) Impact of the plan on the structure and future of the Medicare program, including the proposed Medicare drug benefit;
- (9) Alternatives to the plan, including single-payer options, and other managed-competition options;
- (10) Administrative simplification under the plan;
- (11) Quality assurance;
- (12) Fraud and abuse measures;
- (13) Retiree health benefits;
- (14) Long-term care benefit;
- (15) Proposed standard health benefit package;
- (16) Graduate medical education and academic medical centers;
- (17) Impact of the plan on other affected groups and individuals.

Hearings also will be scheduled by the full Committee on Ways and Means to consider financing issues (other than Medicare savings proposals) and other tax-related matters.

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD:

Members of Congress, individuals and organizations interested in presenting oral testimony before the Subcommittee must submit their requests to be heard by telephone to Harriett Lawler, Diane Kirkland or Karen Ponzurick [(202) 225-1721] no later than the close of business on Friday, October 15, 1993, to be followed by a formal written request to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. The staff will notify by telephone those scheduled to appear as soon as possible after the filing deadline and after additional hearings have been scheduled.

Individuals and organizations must specify in their requests to testify on which topic they would like to be heard. Given the limited time for the Subcommittee to hear from public witnesses, it is likely that witnesses will be restricted to one scheduled appearance before the Subcommittee. Additional comments on other aspects of the President's proposals may be submitted for the printed record of the appropriate hearing.

It is urged that persons and organizations having a common position make every effort to designate one spokesperson to represent them in order for the Subcommittee to hear as many points of view as possible. Witnesses are reminded that the Subcommittee has held extensive hearings on various health reform issues earlier this year. To the extent possible, witnesses need not restate previous testimony heard by the Subcommittee.

Time for oral presentations will be strictly limited with the understanding that a more detailed statement may be included in the printed record of the hearing. In addition, witnesses may be grouped as panelists with strict time limitations for each panelist.

In order to assure the most productive use of the limited amount of time available to question hearing witnesses, all witnesses scheduled to appear before the Subcommittee are requested to submit 300 copies of their prepared statements to the Subcommittee office, room 1114 Longworth House Office Building, at least 24 hours in advance of the scheduled appearance. Failure to comply with this requirement may result in the witness being denied the opportunity to testify in person.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:

Persons submitting written statements for the printed record of the hearing should submit at least six (6) copies of their statements by the close of business on the last day of the hearings, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, room 1114 Longworth House Office Building, before the final hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

FOR IMMEDIATE RELEASE
WEDNESDAY, OCTOBER 6, 1993

PRESS RELEASE #19
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES ADDITIONAL HEARINGS
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will continue its series of hearings on issues relating to the President's health care reform proposals with two hearings focusing on testimony from Administration witnesses.

The hearing previously announced for Tuesday, October 12, 1993, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m., will begin at 10:30 a.m. All other details for this hearing remain the same. (See Subcommittee press release #18, dated September 30, 1993.)

The Subcommittee will continue its hearings on Friday, October 15, 1993, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m. The dates, times, and rooms for subsequent hearings will be announced at a later date.

In announcing the hearings, Chairman Stark said: "The President has put forward a comprehensive and complex plan to address the critical goals of universal coverage and cost containment. As a follow-up to full Committee hearings with the First Lady and Secretary Shalala, the Subcommittee will hold two hearings with additional Administration officials to explore the proposed health plan in detail."

Oral testimony will be heard from invited and public witnesses during the course of the Subcommittee hearings on the President's proposals. For further details about these hearings, see Subcommittee press release #18, dated September 30, 1993.

BACKGROUND:

On October 12, the Subcommittee will receive testimony from the Administrator of the Health Care Financing Administration, the Honorable Bruce C. Vladeck. Mr. Vladeck's testimony will focus on various aspects of the President's proposal, including the methodology for controlling the rate of growth in public and private health care spending, the employer and individual mandates, subsidies for firms with fewer than 50 employees, subsidies for low-income individuals, retiree health benefits, the Medicare prescription drug benefit, and more generally, the future of the Medicare program.

Judy Feder, Ph.D, Principal Deputy Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, will appear before the Subcommittee on Friday, October 15th. Dr. Feder's testimony will cover issues of governance under the Administration's health care reform plan, including the role of the States, various Federal agencies, the National Health Board and the alliances. She will also focus on essential providers, insurance reforms and long-term care.

* * * CHANGE IN SCHEDULE * * *

FOR IMMEDIATE RELEASE
FRIDAY, OCTOBER 8, 1993

PRESS RELEASE #19-REVISED
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES SCHEDULING CHANGES FOR HEARINGS
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today scheduling changes for the hearings on issues relating to the President's health care reform proposals with testimony from Administration witnesses. (See Subcommittee press release #19, dated October 6, 1993.)

The hearing previously announced for Tuesday, October 12, 1993, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:30 a.m., will be held on Thursday, October 14, beginning at 10:00 a.m.

On Thursday, October 14, Judy Feder, Ph.D., Principal Deputy Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, will appear before the Subcommittee. Dr. Feder's testimony will cover issues of governance under the Administration's health care reform plan, including the role of the States, various Federal agencies, the National Health Board and the alliances. She will also focus on essential providers, insurance reforms and long-term care.

The Administrator of the Health Care Financing Administration, the Honorable Bruce C. Vladeck, originally scheduled to appear on Tuesday, October 12, 1993, instead will appear before the Subcommittee on Friday, October 15, 1993, at 10:00 a.m. in the main Committee hearing room, 1100 Longworth House Office Building.

Mr. Vladeck's testimony will focus on various aspects of the President's proposal, including the methodology for controlling the rate of growth in public and private health care spending, the employer and individual mandates, subsidies for firms with fewer than 50 employees, subsidies for low-income individuals, retiree health benefits, the Medicare prescription drug benefit, and more generally, the future of the Medicare program.

For additional information about these hearings and other Subcommittee hearings, see Subcommittee press releases #18, dated September 30, 1993, and #19, dated October 6, 1993.

* * * * *

FOR IMMEDIATE RELEASE
FRIDAY, OCTOBER 15, 1993

PRESS RELEASE #20
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES ADDITIONAL HEARINGS
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee has scheduled two additional hearings as part of its series of hearings on issues relating to the President's health care reform proposals.

The Subcommittee will hold a hearing on Thursday, October 21, 1993, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:30 a.m., with testimony from representatives of consumer groups.

On Friday, October 22, 1993, the Subcommittee will hear testimony from provider groups beginning at 10:00 a.m. in the main Committee hearing room, 1100 Longworth House Office Building.

Witnesses for these hearings will include both invited witnesses and individuals and organizations who have requested an opportunity to testify before the Subcommittee. All witnesses who will appear at these hearings, however, will be notified in advance by the staff.

The dates, times, and rooms for subsequent hearings will be announced at a later date. Oral testimony will be heard from invited and public witnesses during the course of the Subcommittee hearings on the President's proposals. For further details about the hearings, see Subcommittee press release #18, dated September 30, 1993.

* * * * *

FOR IMMEDIATE RELEASE
WEDNESDAY, OCTOBER 20, 1993

PRESS RELEASE #21
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES ADDITIONAL HEARINGS
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee has scheduled additional hearings as part of its series of hearings on issues relating to the President's health care reform proposals.

The dates, times, rooms, and topics for the additional hearings are as follows:

Tuesday, October 26	9:00 a.m.	1100 Longworth	Provider groups
Thursday, October 28	10:00 a.m.	1100 Longworth	Labor representatives
Tuesday, November 2	10:00 a.m.	1100 Longworth	Long-term care issues
Thursday, November 4	11:00 a.m.	1100 Longworth	Impact on the economy and jobs
Friday, November 5	10:00 a.m.	1100 Longworth	Role of State governments and health alliances
Tuesday, November 9	10:00 a.m.	1310A Longworth	Issues relating to risk selection and adjustment by health plans
Monday, November 15	10:00 a.m.	1310A Longworth	Health care cost containment

Witnesses for these hearings will include both invited witnesses and individuals and organizations who have requested an opportunity to testify before the Subcommittee. All witnesses who will appear at these hearings, however, will be notified in advance by the staff.

The dates, times, and rooms for subsequent hearings will be announced at a later date. Oral testimony will be heard from invited and public witnesses during the course of the Subcommittee hearings on the President's proposals. For further details about these hearings, see Subcommittee press release #18, dated September 30, 1993.

* * * * *

* * * CHANGE IN ROOM AND TOPIC * * *

FOR IMMEDIATE RELEASE
MONDAY, NOVEMBER 8, 1993

PRESS RELEASE #21-REVISED
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A CHANGE IN ROOM AND TOPIC FOR THE HEARING ON
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, today announced that the Subcommittee hearing on the President's health care reform proposals scheduled for Monday, November 15, 1993, at 10:00 a.m. in room 1310A Longworth House Office Building, will be held instead in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m. (See press release #21, dated Wednesday, October 20, 1993.)

The topic of this hearing will not be health care cost containment. Testimony will be heard instead from public witnesses on issues relating to benefits under the President's health care reform proposals.

The Subcommittee hearing on health care cost containment will be rescheduled at a later date.

* * * * *

FOR IMMEDIATE RELEASE
FRIDAY, JANUARY 14, 1994

PRESS RELEASE #23
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES ADDITIONAL HEARINGS
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee has scheduled two additional days of hearings to receive testimony from the public, as part of its series of hearings on issues relating to the President's health care reform proposals.

The first hearing will be held on February 1, 1994, in room 1310A Longworth House Office Building. This hearing will begin at 2:30 p.m. or, if necessary, upon completion of the earlier full Committee hearing.

The second hearing will be held on Friday, February 4, 1994, beginning at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.

Witnesses for these hearings will be individuals and organizations who have previously requested an opportunity to testify before the Subcommittee, in accordance with Subcommittee press release #18. All witnesses who will appear at these hearings will be notified in advance by the staff.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:

Persons submitting written statements for the printed record of the hearings should submit at least six (6) copies of their statements by the close of business on the last day of the hearings, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, room 1114 Longworth House Office Building, before the final hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record, or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

* * * * *

* * * NOTICE -- CHANGE IN TIME * * *

FOR IMMEDIATE RELEASE
MONDAY, JANUARY 24, 1994

PRESS RELEASE #23-REVISED
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A TIME CHANGE FOR HEARING
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, today announced that the Subcommittee hearing on the President's health care reform proposals previously scheduled for Tuesday, February 1, 1994, at 2:30 p.m. in room 1310A Longworth House Office Building, will begin instead at 10:00 a.m.

All other details for the hearing remain the same. (See Subcommittee press release #23, dated January 14, 1994.)

* * * * *

Chairman STARK. Good morning. The Health subcommittee of the Committee on Ways and Means will pick up from 2 weeks ago when President Clinton presented us with an outline of a bold and sweeping proposal that would reform our Nation's health care system. The proposal offered the promise of assuring all Americans the security of never losing their health insurance, and the promise of slowing the rapid growth of health care costs. I commend the President for his leadership in these areas.

It is time for this committee now to get down to work: To fulfill these promises by enacting workable, national health care reform legislation. It won't be an easy task. The members of this subcommittee are among the major proponents of every model of reform that has been seriously proposed and perhaps a few that haven't been proposed.

Over the next few months this subcommittee will work its way through the various pieces of the President's plan. The plan is both comprehensive and complex. It will take some time for members and the public to develop a thorough understanding of all of its technical components. We also will have to consider the various alternatives that have been put before us.

During this process, we will find that some pieces of the President's plan will work as advertised, and I expect that these will be adopted into the final package with only minor adjustments. The sections on insurance reforms, administrative simplification, fraud and abuse may fall into this category.

Other sections of the President's plan with laudable objectives may need more work. For example, while we must provide some form of assistance to low-income persons, the system of low-income subsidies proposed by the administration may have the unintended consequence of perpetuating the two-tiered system of care that exists in many communities today. If this is true, the Chair would hope that we could develop alternative methods for achieving the same purpose.

There will also be areas where members have fundamental disagreements with the approach taken by the administration. For example, I have made no secret of the fact that I have grave concerns with the proposal to invest the States with the primary responsibility to implement and enforce many elements of the plan. I am sure that each member of this subcommittee has his or her list of concerns. Each issue will have to be addressed and resolved as we proceed through the legislative process.

Finally, we will have to assure ourselves, and our constituents, that the final package is financially in balance. Before legislation is enacted, we will need to be sure that all of the various sources of revenues, subsidies, payments by States, and savings in Federal programs will fully and fairly finance the benefits that are being promised to every American.

It is going to be very easy to fail. We must enter into this effort in the spirit of cooperation and compromise with the certain knowledge that failure would be a tragedy for all Americans.

Today we begin this subcommittee's trip down this long and treacherous road. Our witnesses this morning include representatives of employers, insurers and providers. I am sure they will help us identify major issues and questions about the President's plan.

Before proceeding with the hearing, I would like to recognize the distinguished ranking member of the minority, Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman. We have already had a number of subcommittee hearings over general topics so that we can prepare ourselves to begin looking at the specific plans. I think we need to remind ourselves that as we attempt to overhaul the health care system with all the perils the chairman has outlined, that we will be doing it under the structure of politics which is basically the process of determining who gets what, when, and how.

When I look at the President's plan, it is, if nothing else, very attractive politics. It provides security for all, new benefits for the elderly, subsidies for larger firms, an early retirement, buy downs for smaller firms, subsidies on the cost of the package buy downs and a bonus of \$91 billion in deficit reduction. All this is paid for, basically, by a tobacco, or sin, tax and by squeezing out of waste, fraud, and abuse in the structure.

Very powerful politics, but as the chairman said, I am concerned whether or not the mechanics of how it operates will deliver what is promised and whether or not what is delivered is really what the American people want.

Second, I am concerned about the fact that as the First Lady presented the package to us she was quite firm in her resolve that certain numbers within the package had been scrubbed inside by all appropriate government agencies and outside by major firms that simply by their names on the list indicated that the numbers were of sterling quality and would stand up under any examination.

Apparently we have not gotten the same scrubbing on the JOBS question. All of a sudden the economics that produced those very precise numbers which would allow you to not only determine the amount that you were going to get from Medicare, but where the money is going in the short term and the long term, on charts prepared by the administration, become a difficult and dismal art and just a set of shoulder-shrugging exercises on exactly what kind of jobs are going to be affected in this country, not only on the amount, but where.

Admittedly, some of those questions are difficult, but I don't think they are any more difficult than those on the other side of the equation to which they have very specific answers. So one of the things I will be asking witnesses, especially those with fairly broad-based national operations who have prestigious economics operations within them, is if they would be willing to lend their expertise so that the administration can scrub the job estimation questions as thoroughly as they have scrubbed the waste, fraud, and abuse savings within the system.

I look forward to the testimony, Mr. Chairman.

Chairman STARK. Are there other members who have opening statements? Mr. Grandy.

Mr. GRANDY. Mr. Chairman. Thank you, Mr. Chairman. I want to pick up slightly on what my colleague, Mr. Thomas, said about numbers.

Last week when the First Lady appeared before the full committee I addressed a question about the cost of adding early retirement benefits to the Clinton plan and what the 5-year cost of that would be. She thought that would probably be \$4.5 billion over 5

years. It was later revised by Mr. Magaziner that it would be \$4.5 billion per year over 5 years, a significant change and shift, obviously, in the numbers, and something of which we have to be mindful.

With that in mind, I am sure every member of this committee knows that yesterday Mr. Andrews, Mrs. Johnson and myself, along with other members of the Republican and Democratic Party, introduced the "Managed Competition Act," I hope that, in addition to the President's proposal, it will be addressed in this committee, because although it is controversial and has proponents and opponents I think it deserves to be considered in the framing of this debate.

My only purpose in offering an opening statement is although the hearing is ostensibly to review the President's proposal there are other proposals that I think are credible will emerge in the final comprehensive benefit package that we may or may not pass. I intend to use my position on this committee to address some of those questions to our witnesses. Thank you, Mr. Chairman.

Chairman STARK. Thank you. I would like to repeat something I said in the hearing the other day, which applies to the Chair as well as each member. As the members well know, as we go through this, for better or for worse, the numbers with which we will have to deal are those numbers determined by the Congressional Budget Office. We can save ourselves a lot of time and agony wondering about what other estimators will come up with in terms of numbers, because when the final estimate comes down we are going to have to deal with CBO and the Joint Committee on Taxation, and take the bitter with the sweet.

I think we are all content that while we may think they make mistakes, they are bipartisan in the way they make mistakes. I am going to ask the committee's indulgence if we can stay away from the numbers challenges until we all have the ones with which we will have to try and bring this legislation together. That is not to suggest that opinions as to the ability of a variety of approaches to accrue savings or raise revenue certainly won't be interesting to all of us. But to be critical of numbers until we have them, it is as difficult for me to adhere to that admonition as I suspect it will be anyone else.

If none of the other members has a statement, I would like to introduce our first panel comprised of two witnesses representing employer groups, Dr. Anne Marie O'Keefe, the director of public policy of the Washington Business Group on Health and William Archey, senior vice president for policy of the U.S. Chamber of Commerce. He is accompanied by Kristin Bass. Welcome.

As I will suggest to all witnesses today, without objection, the full written statements will be part of the record of this hearing and I would ask all witnesses to limit their oral statements to 5 minutes. They may add to them or summarize them and that will allow adequate time for members to explore particular issues of interest in more detail.

With that request, I would like to ask you to proceed in any manner you are comfortable. Dr. O'Keefe, do you want to lead off?

**STATEMENT OF ANNE MARIE O'KEEFE, PH.D., J.D., DIRECTOR,
PUBLIC POLICY, WASHINGTON BUSINESS GROUP ON HEALTH**

Ms. O'KEEFE. Thank you, Mr. Chairman and distinguished members of the committee. The Washington Business Group on Health was founded 20 years ago by a small group of large employers who realized they were paying for health care services for their employees, but they didn't even really know what it was they were buying.

Today WBGH includes almost 200 members, most of whom are Fortune 500 companies and its 20-year history represents the evolution of these large employers from merely passive payers for health care services to aggressive purchasers of health care for their employees. All of our member companies have gotten very good at it.

The bottom line discovery was that these companies were not able to control the discrete problems in health care—that is, problems with access and cost and the uneven quality of health care—until and unless they controlled the way health services are delivered. That is why our signature buttons read, “It is the delivery system, stupid.” That is what our member companies figured out and that is what they have been doing.

Health reform in this country didn't really begin at the political level. Health reform has been going on in the business community for years now in this country. These companies aren't complaining about the problems in health care; they are fixing them. And they have done so well in the last couple of years that they can only imagine what they might have accomplished if the rest of the health service delivery system were in better shape.

That is why WBGH and its members would find it an intolerable irony if in an attempt to reform the health care system we fail to build on what those large employers have done, but merely push them out of the health care market. It is also an irony that at the time when the Clinton administration is recommending streamlining and downsizing government, it is proposing what appears to be a huge bureaucracy to replace employer involvement in health care.

The basis for our recommendations for reform are in what we call organized systems of care which are the equivalent of what the administration used to call accountable health plans. These are systems that integrate the financing and delivery of health services using multidisciplinary panels of providers, furnishing comprehensive services to the people they care for in a coordinated manner that is managed for optimal outcomes.

Our employers select these providers based on hard bargaining and negotiation and they do it using criteria that they have developed to measure quality and cost containment. Originally, when our employers went seeking for good health systems to make available to their employees, they discovered they didn't even have a way to talk with these systems. When they asked questions, for example, that would have relied on data management and integrated medical records, the answers weren't available. So our employers worked in partnership with these systems to develop that information and those evaluation systems.

These long-term partnerships and ongoing communication and negotiations between our employers and their health care systems produce continuing quality improvements in these systems. And I

emphasize that it is quality that has driven these systems. By concentrating on the quality of care available to their employees, our employers found their costs dropped the way they never did when they attempted to use direct cost controls.

From this brief outline, it is easy to see our areas of agreement with the administration. We encourage the networking of providers into organized systems of care and the emphasis on quality. And we certainly endorse the goal of universal coverage.

Our areas of disagreement are the very high thresholds for the mandatory participation in the regional alliances, which would put many small purchasing groups that have also experienced a great deal of success out of business. We advocate a threshold of 100 for mandatory inclusion in regional alliances and we have for several years.

In addition, the President's proposal seems to contain many other burdens to continuing employer involvement. For example, the requirements to form corporate alliances appear to be so onerous that we are afraid the employers will disconnect and walk away. We also think it is very important to include the full population in system reform and that means the Medicare population, the very people who need coordinated, well-managed care the most.

For the same reason we endorse the principle of enterprise medical liability within a system of full tort reform.

Chairman STARK. Thank you very much.

[The prepared statement follows:]

TESTIMONY OF ANNE MARIE O'KEEFE WASHINGTON BUSINESS GROUP ON HEALTH

Good Afternoon. I am Anne Marie O'Keefe, Director of Public Policy for the Washington Business Group on Health (WBGH). WBGH is the only national organization representing large companies solely on issues related to health care. Our membership includes 200 of the nation's largest employers, including both private and public members. Since 1974, WBGH and our members have been involved in public and private sector efforts to improve health care delivery and financing.

Over the years, WBGH's member companies have amassed great skill and experience in providing high quality care for their employees at reasonable prices through negotiations and selective purchasing. They have accomplished this despite the additional costs shifted onto them from uncompensated care, and other inefficiencies in the health care system. Our member companies are anxious to ensure that the entire system is reformed to enable them to continue these programs.

I appreciate the opportunity to share what WBGH and our members have learned over the last two decades at this important time in our history.

Delivery System Reform

The Washington Business Group on Health supports the President's emphasis on a fundamental restructuring of the health care delivery system. WBGH envisions a health care system by the year 2000 that makes high quality health care available to all Americans, at an affordable cost, and which builds continuous quality improvement into the health system itself. Achieving this will require us to begin immediately making fundamental reforms in a partnership of government with health care providers, purchasers and consumers.

The current problems with the quality of health care in this country, which are closely linked to the cost problem, are symptoms of the fragmented way that health care is organized and delivered. Most care is delivered on a piece work basis. Providers operate independently, without accountability for results or cost.

Some believe that utilization review should insure the quality and continuity of health services. But we have found that typically, UR programs simply attempt to "inspect in" quality. The multitude of specialists who treat a seriously ill person are often poorly coordinated. Incentives to improve quality and to manage costs are fewer and far between. Even those providers who want to perform these roles for their patients usually lack the tools to do so.

WBGH's goal is to structure a different way of delivering care. WBGH believes that effective health system reform must change how health providers are organized and how care is delivered, as well as how care is financed. Absent such restructuring, and the information necessary to do it right, proposals to control costs and other financing solutions would simply incorporate the tremendous current costs of inefficient health care delivery.

We believe that enrollment of virtually the entire population, including Medicare beneficiaries, into a limited number of competing, vertically-integrated networks of selected providers will achieve the cost savings that have eluded past attempts at cost containment. A number of large companies and purchasing groups comprised of smaller employers have already implemented programs that closely resemble WBGH's vision. These companies and purchasing groups are providing the laboratories to test the organized systems of care (OSC) concept.

WBGH stresses the need for continuing active management of these new systems by purchasers. Allowing health care to organize itself around individual consumers' choice of plans without sophisticated purchasers playing a role in specifying standards and directing volume, will not solve our health system's key problems. We will only succeed if multiple large purchasers, each with a stake in the health system's cost and quality, are permitted to drive OSCs to improve their performance.

WBGH's vision builds on the success of current innovations underway by leading-edge private and public purchasers, health care coalitions, managed care companies, hospitals, community health centers, physicians and other allied health professionals, and consumers. For example, Southwestern Bell, Honeywell and Southern California Edison have all used elements of the

organized systems of care strategy to hold their annual cost increases to levels well below the national average. Kaiser-Permanente has done the same for its subscribers. Many of the small to mid-size businesses with whom WBGH works through the National Business Coalition Forum on Health have formed purchasing groups to encourage delivery systems to incorporate aspects of OSCs.

It is important to emphasize that these state-of-the-art programs are not designed solely to achieve cost savings. They also promote quality care and provider accountability. For example, Honeywell and Xerox have worked very closely with their provider networks to develop standards by which these purchasers can measure the quality of care and monitor their delivery systems' ability to continuously improve that quality and meet the objectives of cost containment.

For years, the Washington Business Group on Health has argued that we cannot fix the discrete problems in our health system -- burgeoning cost, uneven quality and limited access -- until and unless we fix the way health services are delivered. Our signature buttons read *It's the delivery system, stupid.*

Organized Systems of Care

Our use of the term "organized systems of care" is comparable to the "accountable health plans" currently being discussed in reform proposals, although we believe that we have defined the term more completely. The concept is one of a unified and accountable health care delivery system that serves all Americans and replaces the fragmented systems which operate today.

Organized systems of care (OSCs) are integrated financing and delivery systems that use multidisciplinary panels of providers selected on the basis of quality and cost management criteria to furnish comprehensive services. The systems incorporate incentives to provide only appropriate and necessary care into their operations and are accountable to patients and purchasers on the basis of quality, cost, and outcomes.

Using one system that both provides care and assumes financial risk ensures efficient, coordinated and well managed care.

Areas Of Agreement With The Health Security Act

WBGH supports many of the concepts included in the President's proposal, although I must emphasize that ultimately, our position will be determined by how these concepts would be applied in practice. While we reserve judgement on some of the particulars in the Health Security Act, the concepts we support include the following.

WBGH and our member companies strongly support the inducements in the President's plan for health providers to organize themselves into systems that merge accountability for service delivery and financial risk. We also enthusiastically support the plan's incentives for consumers to choose these efficient plans, rather than continue purchasing fee-for-service care that is uncoordinated and unmanaged.

Our member companies have learned that cost controls neither control costs nor assure the quality of care delivered to their employees. Rather, our companies have achieved success along both of these dimensions by concentrating on quality, which can best be assured by systems that manage care and coordinate services for optimal outcome. We heartily endorse those features of the Health Security Act that would support these quality controls in the reformed health system.

Like President Clinton, the member companies of the Washington Business Group on Health support a uniform, national benefit package that would allow purchasers and consumers to shop for health coverage on the basis of quality and cost. The emphasis on health promotion and disease prevention in this benefit package is philosophically and financially wise. Many large employers have found that health promotion and disease prevention programs are not only cost-effective but also improve the health and well-being of their employees.

WBGH strongly supports the plan's proposals to simplify the administration of health services,

including standardizing claims forms and integrating medical records. We applaud efforts to increase the number of primary care providers, and to fully utilize the training, skills and experience of nonphysician providers.

Perhaps most important, we agree with nearly all Americans that health care must be available to everyone, regardless of the circumstances of an individual's past medical history, employment status or personal wealth.

Small Market Reform And The HIPC Threshold

Health reform must redesign the purchaser market to pool individuals and fragmented small groups into coalitions that are large enough to achieve economies of scale. The current fragmentation of buyers' purchasing power is one of the key reasons our health care system is so wasteful and costly. The present small group market is the most extreme manifestation of this problem.

For all practical purposes, small employers have no market power. That is, a small group's decision to switch carriers has little impact on the overall markets of insurers and providers. This gives insurers and providers little incentive to respond to small groups' needs. Similarly, many of the small insurers operating in the small group market have little leverage over providers.

In contrast, pooling small employers with 100 or fewer employees would give these small groups substantial leverage over insurers and providers. Carriers participating in these small group pools would cover enough lives to gain substantial leverage over providers. This leverage could be used to avoid cost shifting, to obtain favorable financial arrangements, and to insist that providers meet reasonable performance standards.

Purchasing cooperatives can provide small businesses with the market clout, technical expertise and coverage options which have enabled many large employers to contain cost and improve the quality of care offered to their workers.

Malpractice reform

WBGH commends President Clinton's recognition that America's medical liability system must be part of comprehensive health system reform. We do believe, however, that the President has not gone far enough to ensure that the malpractice system effectively deters negligent medical care, resolves claims in an efficient and equitable manner, and maintains access to needed services while encouraging appropriate quality care. Enterprise medical liability is an essential component of comprehensive health system reform.

To reinforce the accountability of an organized system of care in all aspects of its performance, medical liability would be an effective method of deterring negligent care. Enterprise liability would ensure that all malpractice claims are filed against the organized system of care rather than against individual practitioners, would provide a strong incentive for OSCs to maintain quality while controlling costs.

Conclusion

WBGH is very excited about Administration and Congressional attention to the need for significant restructuring of the health care delivery system. To ensure continual improvement of the quality and cost-efficiency of these systems, WBGH believes the purchaser market must build on and encourage current large employer, and purchasing coalition efforts.

Chairman STARK. Mr. Archey.

STATEMENT OF WILLIAM T. ARCHEY, SENIOR VICE PRESIDENT FOR POLICY AND CONGRESSIONAL AFFAIRS, U.S. CHAMBER OF COMMERCE

Mr. ARCHEY. Thank you, Mr. Chairman, and I would note that I am accompanied by Kristin Bass, our manager for human resources policy who has had 10 hard years of experience with health care delivery and other aspects of the health care system.

It is a pleasure for me to be representing the U.S. Chamber federation, which includes some 3,000 local and State chambers of commerce, and 1,200 trade and professional associations, 68 American chambers of commerce overseas and 215,000 direct business members of which 96 percent employ fewer than 100 people.

I would like to, before talking about specifics of the Clinton plan, make some, if you will, prefatory remarks to provide context. Irrespective of what you might have read in today's newspaper, we have not endorsed any specific proposal.

We, in fact, find there are things that we like in the President's proposal and things we do not like in the President's proposal. There are a number of things in the Managed Competition Act of 1993 that we like a great deal and there are some things in that that we do not like. But we have not endorsed any proposal, nor do we intend to do so for some time.

The reason for that is that this is without question the most complex issue facing the chamber and its membership, and probably will be the most complex issue that will face the chamber and its membership for the remainder of this decade.

There is a clear need in our judgment in being responsive to our membership and acting responsibly on behalf of that membership to in fact educate the members on the various proposals and to give them the facts and that is what we intend to do. A very concerted effort has begun that will culminate in a series of three national town meetings on the issue of health care proposals that will take place over the next few months.

This is not an issue—as we have come to realize through our surveys and I know the members of this committee have come to that conclusion—this is not an issue on which you can game your constituents or we can game our members. This is an issue in which ultimately our members are going to pull out a piece of paper and pencil and they are going to start running out the numbers and looking at how it affects them and what they get for it. The issue is going to be based on a clear articulation of the facts.

On that note I would like to say something, because I think there has been a misunderstanding about small business being obstructionist to the issue of health care reform. I would like to note that I include in my testimony an article from the *Journal of American Health Policy*. I would like to quote briefly some excerpts from that article written by two academics and a principal from the KPMG, the old Peat-Marwick accounting firm.

The opinions of small business on national health care reform have changed profoundly over the last few years. Small business should not be viewed as a roadblock to reform, but rather as a group that needs to be educated.

Our survey shows that when presented with both sides of the case for reform many businesses are willing to sacrifice for the greater goal of creating positive change in the system.

It references an issue of debate, the whole question of HIPC's or alliances or health care purchasing cooperatives.

The survey noted that small business members given the option of purchasing insurance directly or through a HIPC, if they thought the HIPC would be no better than a neutral deal, that is, no saving of costs, 62 percent of small business prefers to buy it directly. If there is a 15 percent savings in health insurance going through a HIPC, 80 percent of small businesses favor the HIPC.

The interesting thing is that what most of our small businesses don't seem to know is what do you mean when you talk about a HIPC. That is one of the issues that I think anybody who purports to represent their members has got to, in fact, find out and accurately convey. I would also note to you as a point in terms of at least the proposals on the table, our preference is very much to the construction of the HIPC's as is found in the Managed Competition Act of 1993.

On the specifics of the Clinton proposal, we have laid out a number of things in my prepared statement. I would briefly note to you that we are in favor of universal coverage. We are in favor of the notion of shared responsibility to get to it. We have a very large number of problems on the issue of the health alliances, including the question of the savings and revenue assumptions underlying the President's proposal.

On that note I will terminate my opening remarks and await your questions. Thank you, Mr. Chairman.

[The prepared statement and attachments follow:]

STATEMENT
on
THE CLINTON ADMINISTRATION HEALTH CARE REFORM PROPOSAL
before the
SUBCOMMITTEE ON HEALTH
of the
HOUSE COMMITTEE ON WAYS AND MEANS
for the
U.S. CHAMBER OF COMMERCE
by
William T. Archey
October 7, 1993

Good morning, Mr. Chairman and members of the Subcommittee. I am William T. Archey, Senior Vice President for Policy and Congressional Affairs of the U. S. Chamber of Commerce. I appreciate this opportunity to present the Chamber's views on an issue that has become almost as central to us institutionally as it is to each American personally.

As you may know, the Chamber federation includes some 3,000 local and state chambers of commerce, 1,200 trade and professional associations, 68 American Chambers of Commerce abroad, and 215,000 businesses, 96 percent of which employ fewer than 100 people. Roughly two-thirds of these small companies, and virtually all of our larger members, currently provide some form of health insurance for their workers. In the past six years, the overall cost of health insurance for these employers has doubled. Some have been forced to cut back or drop insurance coverage, and many others fear they will have to do the same if relief from escalating costs is not forthcoming. These rapidly growing health care costs have hit small businesses particularly hard. Unlike larger companies, whose size enables them to contract with providers and insurers for discounted services, small companies pay full freight. In addition, they are burdened by costs shifted by hospitals and doctors to make up for uninsured patients unable to pay their bills.

President Clinton deserves credit for moving the health care debate to center stage. As is probably inevitable in something so complex, his proposal has strengths and weaknesses. The Chamber has serious concerns about some aspects of the Clinton plan, such as:

- Regional health alliances that include most of the population instead of focusing on small business.
- A huge new bureaucracy to regulate, monitor, and ultimately tax employers.
- State flexibility to establish independent systems.
- Government-specified premium caps.
- A requirement that employers pay 80 percent of the premium for employees.
- Optimistic savings and revenue assumptions.

We will elaborate on these concerns later in this testimony.

The Chamber supports the need for universal coverage and recognizes that it can only become a reality and be paid for through the shared responsibility of employers, employees, and government. This principle is reflected in the Clinton plan. In addition, some specifics of the Clinton plan consistent with Chamber policy recommendations include:

- Subsidies to help small businesses and low-wage workers afford health insurance.
- Portability of coverage.
- Streamlining the processing of health insurance claims.
- 100 percent deductibility of basic health insurance costs for the self-employed.

Chamber members recognize that employers have a critical role to play in reforming our health care system. We are in favor of a system that achieves affordable health insurance coverage by building on the strong current base of employer-provided health benefits. Our members maintain that health insurance should remain part of the compensation package. This may seem surprising in light of the small-business alarms sounded so frequently in the news. What we have found, though, is that small business views on health care policy do not necessarily follow traditional ideological lines. We recommend to your attention a study published in the September/October issue of the Journal of American Health Policy (copy attached). Its authors found a variety of views within the small business community and noted that "small businessmen and women are more open to health care reform than conventional wisdom holds." Most small businesses that do not provide health insurance to employees cite high cost as the barrier. If convinced that health insurance could be made more affordable through pooled purchasing, four-fifths of small businesses surveyed would favor such a system.

Employers, however, have no wish to claim sole responsibility for insuring the American population. Through shared responsibility, we could make sure that no one would be permitted to opt out of the system or its obligations, and also that no one would be ruined in the process. At the same time, companies now providing insurance would be freed from the additional costs shifted to their bills or premium rates to make up for the uninsured.

While we are convinced that health care costs can only be contained if everyone is in the system and playing by the same rules, we recognize that some individuals and employers are unable to afford insurance. We believe that individuals should be required to have insurance coverage, while employers should make insurance available to workers and dependents and contribute something to its cost. However, as we told the White House task force from the very beginning, the Chamber opposes any health insurance requirement that does not include adequate subsidies for low-wage workers and their employees.

We think this is an area where the Administration listened to us. The Clinton proposal incorporates both a small-business subsidy in the form of an expenditure cap on percentage of payroll and an individual subsidy for those whose incomes are below 150 percent of the poverty level. We think these provisions would help make insurance affordable.

To elaborate on the concerns sketched earlier:

- **Regional health alliances** that are so large they absorb virtually the entire population. The Chamber has long supported pooled purchasing arrangements (whether called alliances, or HIPCs, or whatever) for small businesses. Statistics indicate that it is among employees of small businesses that the greatest coverage gaps exist, and it is these companies that need to band together to achieve economies of scale. In this way, small businesses and individuals will finally have the leverage to compete against larger companies in the market for health insurance. Many of our smaller members eagerly welcome the idea of one-stop shopping -- that they can call and get from a single source all necessary information about health care plans, prices, and quality without having to spend hours on the phone calling around to agents. These members remind us that they are in the business of selling hardware or lumber or manufacturing coolers and have neither the time nor the expertise necessary to sift through health insurance policy language to find the appropriate features and the best deal. To concentrate assistance where it is needed, the Chamber would set the ceiling for required

participation in a regional alliance at 100 employees. To guard against adverse selection, we would advise against allowing large companies to opt into the alliance.

Larger companies should be permitted to choose commercial insurance, form purchasing groups among themselves, or self-insure. Large self-insured companies have driven much of the innovation in cost containment, managed care, and wellness programs. We believe that their energy and creativity should be preserved in our health care system. If such companies no longer are able to reap the cost savings from improving their group experience, there is little incentive for them to continue to develop and maintain such programs. Large companies community rate their employees, and do not discriminate on the basis of health status. Reform should focus on the parts of the system that don't work -- not the parts that do work..

- **Over-reliance on government regulation and bureaucracy** to contain health care costs and oversee the operational details of the health care system. The Clinton plan would vest substantial regulatory power in a new National Health Board, granting it authority for tasks ranging from modifying the guaranteed benefit package to setting the national health care budget to disciplining alliances and states that fail to meet budget targets. Such a weight of federal oversight is bound to hamper efficient operation of the market, and is counter to a professed intent to streamline the health care bureaucracy that already exists.

- **State flexibility** to establish separate health care systems. In today's competitive global economy, such fragmentation is ill-advised. Multi-state companies potentially will be forced to squander resources on complying with 50 different sets of rules at a time when American companies need to focus on improving productivity to meet foreign competition. To help states go their own ways, the Clinton proposal makes a series of changes to the Employee Retirement Income Security Act of 1974 (ERISA) that would vitiate the preemption provisions at its very center. ERISA preemption now allows self-insured plans to rely on a single federal regulatory standard; indeed, it was the creation of such a standard that persuaded the business community to support ERISA at the time of its enactment.

- **Government-specified premium caps**, rather than market forces, setting the rate at which health insurance premiums could increase. A properly functioning market is a more efficient resource allocator than a government agency. The adoption of premium caps would freeze in place historical inefficiencies, such as regional variation in practice patterns and pricing. For example, Mrs. Clinton has noted that average per-patient Medicare costs in the Boston area are twice as high as those in New Haven, without any discernable difference in overall patient well-being.

- **A premium split** that places a disproportionate burden on employers. Requiring employers to pay 80 percent of the health insurance premium insulates employees from the consequences of their own purchasing decisions. Consumers need to be aware of how much health care really costs. We also question basing the required payment on the weighted average premium in a regional alliance. Given that all plans would have to offer the guaranteed benefit package, consumers could be encouraged to choose less expensive plans if the employer contribution were pegged to the average of the lower third or half of plans in the alliance.

- **Savings and revenue assumptions** that could prove to be unrealistic. Expanding coverage to bring in an estimated 37 million uninsured at the same time that we guarantee a generous benefit package to all, provide the elderly with prescription drug coverage, and subsidize coverage to early retirees cannot help but be an expensive proposition. It may be that efficiencies can be realized, fraud and abuse curtailed, and wages and profits increased (reflecting health cost savings), thus generating higher tax revenues. The Chamber would be happy to see such results. In the meantime, however, we are wary of counting our chickens before they hatch, and worry about what the financing fall-back might prove to be.

One of the reasons for the President's commitment to health care reform is his desire to bring the federal deficit under control. Since this cannot occur without constraining costs

in federal entitlement programs, the Chamber believes that Medicare and Medicaid must be included in reform measures. As people reach Medicare eligibility, we foresee their choosing to remain in their existing care networks rather than transitioning to an artificially preserved fee-for-service environment. We support the Clinton Administration's decision that Medicaid beneficiaries should be brought into the reform mainstream immediately, obtaining coverage through a purchasing cooperative like any other individuals, but with government assistance to pay the premiums. We also agree that the Medicaid population should be pooled separately for premium purposes, so that small businesses participating in the cooperative are not put in the position of subsidizing the relatively sicker Medicaid population.

Medical malpractice reform is a necessary component of health care reform. The President's proposal includes provisions meant to address this concern, but it does not go far enough to produce real changes in the way physicians practice medicine. So long as doctors still feel the need to practice defensive medicine, serious savings in this area will not be realized.

The Chamber recognizes, as do President and Mrs. Clinton, that this proposal is by no means immutable. It represents the beginning of serious debate and of a public education program. The Chamber is heartened by an emergence of some common themes among a broad spectrum of reform proponents. These themes include portability of coverage, an end to pre-existing condition exclusions, administrative streamlining, and 100 percent deductibility of health insurance costs for the self-employed.

The President's health care plan is one of a number of proposals, several of which deserve serious consideration. The Chamber is encouraged by yesterday's introduction of the Managed Competition Act of 1993, with its bipartisan sponsorship, as a valuable addition to the debate. The Chamber will continue to play a constructive role in the formation of national health care policy by advocating the concerns of the business community as we work to forge a national consensus and enact legislation. We look forward to working with the members of this subcommittee in that process.

Small Businesses' Changing Views on Health Reform

Our national sample of 750 randomly chosen firms with fewer than 50 employees reveals surprising findings about the traditional views of small business on health care reform. A substantial segment of the small business community is sympathetic to health care reform, including such controversial measures as mandating that all employers contribute to the coverage of their workers, limits on health care spending, and altering the tax treatment of employer contributions for health insurance. Without premium savings, fewer than half of small businesses support the concept of health insurance purchasing cooperatives. With premium savings, a majority support it.

By Gail A. Jensen, Robert J. Morlock, and Jon R. Gabel

In the Clinton Administration's quest for comprehensive health care reform, few interests will exert greater influence through the political process than small business. Because Americans tend to romanticize small businesses, the small business lobby — along with the elderly — is one of the most influential interest groups in Washington. Small business is also seen as the engine of economic growth. Between 1982 and 1990, two-thirds of the new jobs created were in the small business sector (Kent, 1993).

The dilemma facing policymakers is that the same small businesses that fuel economic growth are also where an estimated 50 percent of the nation's 36 million uninsured Americans work (Congressional Budget Office, 1991). The

Health Insurance Association of America found, in their national survey of employers, that fewer than 30 percent of firms with 10 or fewer workers offer health insurance to their employees (Lippert and Wicks, 1991). To achieve universal coverage, preliminary versions of the Administration's reform package call for mandatory contributions by all employers toward the cost of health coverage for their employees. Small employers would send their contributions to a health insurance purchasing cooperative (HIPC, also termed health alliance) where their employees would select from a menu of accountable health plans.

The small business lobby, as represented by the National Federation of Independent Businesses (NFIB), is adamantly opposed to the Administration's reform package. For example, NFIB refused a White House invitation to appear on a small business panel for a March 29, 1993, health care task force meeting. Yet the views of the small business community are diverse and occasionally deviate from

those of the small business political lobby.

Using a national survey of 750 firms with fewer than 50 workers conducted in the spring of 1993, we examined the views of the small business community on current proposals for health care reform. Small business owners were asked about the need for reform of the health care system, their views about the fairest way to treat employer contributions to health benefits under the tax code, and how they felt about the basic principle of requiring all employers to contribute to the cost of health insurance. Our findings suggest a variety of views within the small business community and that small businessmen and women are more open to health care reform than conventional wisdom holds.

Methods

In April and May 1993 the survey research firm National Research Inc. of Washington DC conducted telephone interviews with 750 small businesses nationwide.

Gail A. Jensen, PhD, is associate professor, and Robert J. Morlock is research assistant, Institute of Gerontology and Department of Economics, Wayne State University, Detroit. Jon R. Gabel is director of employee benefits research at KPMG Peat Marwick, Inc., Washington DC.

The sample was drawn from the Dun & Bradstreet Corp. (D&B) list of private businesses nationwide that employ fewer than 50 workers. Survey participants were drawn randomly from D&B's list after stratifying by size and location. The sample excluded businesses with no employees and government employers. In advance of the interview, business owners were sent a letter inviting them to participate in the study and indicating when they would be contacted for their interview. At the time of the survey, the interviewer asked to speak with the person most knowledgeable about the fringe benefits the business offered. In most cases that person was the owner, president, or office manager of the firm. In all, 1,721 firms were contacted, and 750 agreed to participate in the survey. This response rate of 44 percent is typical of small business surveys.

Reflecting the probability of selection, each employer was as-

signed a weight. This allowed us to calculate national statistics representing all private businesses employing fewer than 50 workers. The margin of error on estimates from the survey is approximately plus or minus four percentage points.

Size Determines Coverage

We found that 50 percent of all businesses with fewer than 50 workers do not offer health benefits as a fringe benefit. The size of a business, as measured by the number of people it employs, is the single most important predictor of whether it provides health insurance. The larger the firm, the more likely it is to provide coverage.

Our survey found that the percentage of firms offering health insurance is 44 percent among firms employing fewer than 10 workers, 70 percent among firms employing 10 to 24 workers, and 85 percent among firms employing 25 to 49

workers (see Figure 1). Among all firms with fewer than 50 workers, the low overall percentage offering coverage — 51 percent — reflects the fact that the vast majority of firms in this size range employ fewer than 10 workers.

Reasons Against Coverage

Our survey asked firms that do not provide health insurance to indicate why. The most frequent response was that current premiums were simply too high. Eighty percent of small businesses indicated that high premiums were a "very important" factor in the decision not to provide benefits, and another 10 percent indicated that they were a "somewhat important" reason (see Figure 2). Other often cited reasons for not offering insurance were that the firm's profits (79 percent) and/or premiums for insurance (75 percent) were too uncertain from year to year to make a commitment to provide health benefits.

Our survey reveals that most small businesses maintain a high degree of continuity in their insurance offerings. We found that many firms (56 percent) that chose not to offer insurance feared that if they did provide it, they might have to take it away at some future date. It was unusual to find firms that did not provide insurance at the time of our survey had ever provided it. Only 17 percent indicated that they had. Likewise, nearly all firms (89 percent) offering insurance at the time of our survey had offered it for at least the past three years. These findings of a high degree of stability in the insurance offerings of small businesses confirm the findings of earlier surveys on this issue (Lichtenstein and Witte, 1991). Many small businesses, and

Figure 1

The Percentage of Small Firms That Offer Health Insurance by Size of Firm, 1993



Source: Wayne State University/KPMG Peat Marwick, Survey of 750 Small Firms, Spring 1993.

particularly those with fewer than 10 employees, report that qualifying for a policy at group rates is often difficult. Thirty-nine percent of the firms not offering insurance reported that their inability to qualify for coverage at employer rates was a very important reason for not offering coverage. Yet when asked why they were unable to qualify, only about half could give a specific reason. The three explanations, identified with roughly equal frequency, were: the firm was too newly established; the type of business or industry the firm made it ineligible for a policy; or one or more employees could not qualify for insurance because of health conditions.

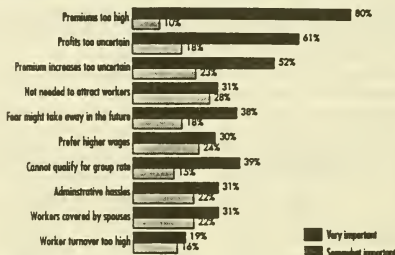
Desire for Reform

Participants in the survey were asked their opinions about some potential reforms of the health care system. Regardless of whether they provide health coverage, most small businesses (75 percent) say they favor a major restructuring of the health care system, 11 percent are opposed to major changes, and the rest gave no opinion. Support for major changes in the system, however, is not synonymous with support for any one particular reform strategy.

To assess the direction in which small business owners felt public policy should go, we asked respondents to comment on the appropriateness of several possible reforms to the health care system. Specifically, we asked them how they felt about: (1) requiring all employers to contribute toward the cost of health insurance for their employees; (2) imposing overall limits or budgets for health care spending; (3) changing the tax treatment of

Figure 2

Why Small Firms Say They Don't Offer Health Insurance



Source: Wayne State University/KPMG Peat Marwick, Survey of 750 Small Firms, Spring 1993.

employer contributions for health insurance; and (4) adopting a "managed competition" model for securing workers' coverage rather than a direct employer provision model.

To elicit their views on the first issue—the desirability of mandating that employers contribute to the cost of health insurance—the interviewer said, "Some employers are concerned about proposed legislation that would mandate all employers to provide or contribute to the costs of health benefits for their employees. Others contend that a mandate is the only fair way to see that everyone has health insurance, and that when Employer A doesn't provide coverage, other employers indirectly pay for the coverage of A's workers. How do you feel about requiring all employers to contribute for the coverage of their employees?"

We wanted the respondent's

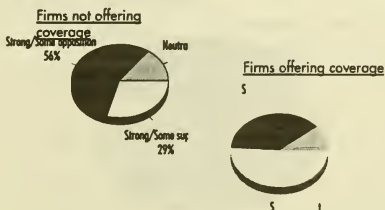
opinion after he or she had heard at least part of the rationale for such a requirement. Small business owners were then asked to indicate whether they strongly support mandated contributions, somewhat support them, are neutral, somewhat oppose, or strongly oppose them.

Our survey found that close to half (42 percent) of all small businesses support the principle that employers should be required to contribute to the cost of health insurance for their employees. Even among firms not currently offering insurance, close to one-third (29 percent) say they support such a requirement. Among firms now providing coverage, 51 percent favor mandated contributions (see Figure 3).

This level of support for a mandate is much higher than earlier surveys of small businesses have found. For example, a 1989 survey of member firms of the NFIB found

Figure 3

Small Firms Offering Health Coverage Have Different Attitudes About Mandated Coverage Than Firms Declining Coverage



Source: Wayne State University/KPMG Peat Marwick, Survey of 750 Small Firms, Spring 1993.

that only 25 percent agreed that "employers have a responsibility to provide employee health insurance," and only 24 percent supported the statement that "employers should be required to provide a basic level of employee health insurance" (Hall and Kuder, 1990). Respondents to the NFIB survey were overwhelmingly small firms, and, at least in terms of their size and industry composition, were similar to the firms covered by our survey.

It is possible that the increased support for a mandate may stem from our questionnaire's format. Unlike previous opinion surveys of small business, our survey attempted to give the respondent information on the case for various reforms. After hearing the argument for the proposition in question, business owners may have been more likely to support it as reasonable. It is also conceivable that the particular

argument for a mandate that we chose to present — that firms not offering coverage end up as free-riders to the health care system — evoked either a sense of guilt or disturbance among some respondents. This might explain why so many (29 percent) of the firms that currently do not offer coverage essentially favor what amounts to a new requirement and cost for them.

On the issue of imposing overall budget limits for health care spending, respondents were simply asked to indicate whether they strongly support such measures, somewhat support them, are neutral, somewhat oppose, or strongly oppose them. Many small business owners (66 percent) indicate that they would like to see overall limits or budgets for health care spending imposed as part of a health care reform strategy. Firms that want a major restruc-

turing of the health care system are most likely to support this particular reform.

To assess business owners' opinions about changing the current tax treatment of health insurance, we took a different approach. We asked small business owners which of three approaches they thought would be the "fairest" way to treat employer contributions for health coverage: (1) "treat all employer contributions for health insurance as tax-free, as they are today"; (2) "tax employer contributions for health insurance the same as wage income"; or (3) "treat employer contributions as tax-free up to the lowest cost plan in an area." Before giving them these choices, however, the interviewer said, "Currently, employers' contributions for health insurance are not treated as taxable income of employees. Some economists contend that this encourages Americans to over-insure and choose Cadillac health plans. Others say that taxing workers for employers' contributions for health insurance would place a greater burden on the middle class. Which of the following is the fairest way to treat employers' contributions for health coverage?"

As with our previous question about required contributions, we wanted to obtain business owners' opinions about changing the tax code after they had heard at least part of the case for reform.

Only a slim majority (60 percent) of small businesses believe that maintaining the status quo is the fairest approach to taxation (see Figure 4). Fifty-two percent of firms that do not now offer coverage believe that the current tax-free status of all employer

contributions to health benefits should be preserved; among firms that offer insurance a slightly higher percentage, 65 percent, believe so. Just over a quarter of businesses (26 percent overall) believe a tax cap on employer contributions is fairest. A small minority (9 percent), concentrated largely among firms that do not now offer insurance, believe that employer contributions for health insurance should be treated the same as wage income.

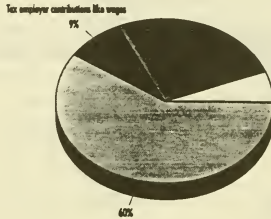
Managed Competition Views

On the matter of managed competition as a model for health care reform, we asked small business owners to indicate which of two approaches they would prefer if they were required to contribute to the cost of workers' health insurance. The choices described were providing group health insurance directly themselves, or contributing to the cost of securing workers' insurance through a HIPC.

The HIPC system that small businesses were asked to consider was described as entailing the creation of new statewide purchasing cooperatives specifically for firms in their size class (fewer than 50 workers). Employers would be required to pay a contribution on behalf of each of their workers, which would be used toward the lowest-cost certified plan in their area. That contribution would then buy an employees' health insurance through the local HIPC, which would offer a wide choice of health plans to employees and would relieve small businesses of having to administer benefits themselves. Survey respondents were asked if they would prefer to pay the contribution to a HIPC or to provide group insurance them-

Figure 4

Almost Half of All Small Firms Are Willing To Change the Tax Treatment of Employer Contributions to Health Insurance



Note: Percentages do not sum to 100 due to rounding.

Source: Wayne State University/KPMG Peat Marwick Survey of 750 Small Firms, Spring 1993.

selves. The firms were also asked what price incentives would cause them to prefer the HIPC model to providing the insurance themselves.

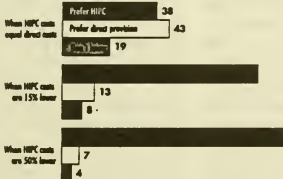
Small business owners' attitudes toward managed competition depend critically on the perceived savings associated with that approach. If a required HIPC contribution will cost firms the same amount as if they purchased health insurance for their employees directly, then most small businesses (61 percent) are unwilling to endorse a HIPC system (see Figure 5). In this case, 43 percent prefer providing health benefits themselves, and 19 percent say they "don't know" which approach they prefer. Firms not now offering insurance are much more supportive of HIPCs than firms currently providing benefits, yet fewer than half

of them endorse the concept (46 percent favor HIPCs compared to 32 percent among firms offering coverage).

If HIPCs can save small businesses money, however, then support for them is actually very strong. Four-fifths (79 percent) say that they would favor a HIPC-type system if it can save them 15 percent over providing insurance directly. Thirteen percent say that they would prefer to provide health insurance themselves, and the rest (8 percent) say they "don't know." If HIPCs can save businesses 50 percent over the cost of direct provision, then nearly all firms (90 percent) endorse them. Interestingly, most of the firms that changed their opinion of HIPCs when the relative price was lowered were

Figure 5

Under What Circumstances Will Small Firms Support HIPC-Style "Managed Competition" Over Direct Provision

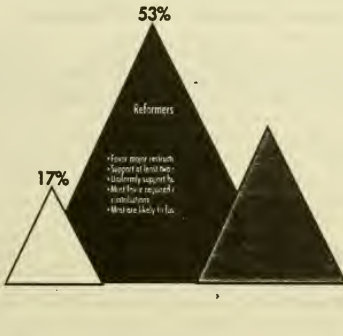


Note: Percentages may not sum to 100 due to rounding.

Source: Wayne State University/KPMG Peat Marwick Survey of 750 Small Firms, Spring 1993.

Figure 6

Political Subgroups Among Small Business



Source: Wayne State University/KPMG Peat Marwick Survey of 750 Small Firms, Spring 1993.

firms that currently provide benefits. The fact that they reversed their preferences so readily reflects the obvious importance they place on saving money on health insurance. Lowering their costs is their primary goal, and if HIPCs can take them there, they will support them.

For our initial HIPC question (about preferences if the employer's costs under both approaches were the same) the high percentage of small businesses that say they "don't know" which they prefer (19 percent) suggests that many of them still don't understand how a managed competition system would work, and they may not understand the full implications of it for their business. Even without such an understanding, however, we found that many of them converted to supporting a HIPC system when they perceived savings under that approach.

These findings convey two messages. First, policymakers will need to carefully explain alternative reform proposals if they wish to elicit the true preferences of small businesses. Second, the overriding concern of small businesses is to save money on the cost of insurance.

Political Subgroups

The above discussion suggests that there is considerable diversity among small businesses in their opinions of various reforms. Although characterizing firm views on a reform-by-reform basis is useful for summary purposes, examining the data in that way does not tell us whether there are certain sets of opinions that tend to go together. For example, do firms that express opposition to one measure also tend to reject

other reforms, or is there any congruence in responses? Alternatively, to what extent do supporters of change in one area overlap the supporters of change in other areas?

We examined our data to determine whether there was a natural segregation of small businesses according to their opinions on the four policy issues discussed in the prior section. Within the small business population, we were able to identify three distinct subgroups of firms: (1) those that support several of the reforms we had them consider, (2) those who oppose almost all of them, and (3) those who are somewhere between these two camps.

The first group, who can be described succinctly as "reformers," consists of firms that say they want a major restructuring

of the health care system and who then back up that position by supporting change in at least two specific areas. Just over half (53 percent) of all small businesses are reformers by these criteria (see Figure 6). They uniformly support global limits on health care spending (91 percent), and most (62 percent) also believe that employers should be required to contribute to the cost of health insurance. They are split, however, in their views on changing the tax code and on the desirability of HIPCs. Fifty-five and 58 percent of reformers, respectively, favor these two possible reforms. As a group, reformers encompass all sizes and types of firms. Indeed, their composition closely mirrors the general population of small businesses.

The second group are best described as "defenders of the status quo." They are small businesses that say they oppose any restructuring of the system and who then go on to reject (perhaps not surprisingly) all, or all but one, of the specific reforms we discussed. They comprise nearly one-fifth (17 percent) of all small businesses. If defenders are willing to support anything, it is almost always changing the current tax treatment of employer contributions for health insurance. Twenty-two percent of defenders do not consider the current tax treatment to be the fairest approach to taxation, but many of them are still undecided as to the best alternative. Firms with more than 10 workers, and those offer-

Figure 7

Support for HIPC-Style "Managed Competition" Varies Sharply by Political Subgroup

Question	Reformer Group	Defender Group	Betwixted Group
Suppose the required HIPC contribution for employee health insurance were to cost you the same as if you purchased health insurance for your employees directly. Which would you prefer: to pay a contribution to a HIPC or provide the group insurance directly yourself?			
Prefer to pay the required HIPC contribution	58	8	20
Prefer to provide group insurance through the firm	27	62	61
Don't know	15	30	19
What if the required HIPC contribution were to cost your firm 15% less?			
Prefer to pay the required HIPC contribution	87	47	79
Prefer to provide group insurance through the firm	7	34	12
Don't know	4	19	9
What if the HIPC contribution were to cost your firm 50% less?			
Prefer to pay the required HIPC contribution	96	69	90
Prefer to provide group insurance through the firm	3	22	5
Don't know	1	9	5

Source: Wayne State University/KPMG Peat Marwick Survey of 750 Small Firms, Spring 1993.

ing health insurance, are most likely to defend the status quo. Not surprisingly, defenders are more than twice as likely as reformers to reject HPCs as a means of providing coverage (62 percent compared to 27 percent favor direct provision) (see Figure 7). Their attitude toward HPCs is consistent with their rejection of the other reforms that were presented to them.

The third group, which accounts for 30 percent of small businesses, are firms that do not fit either of these profiles. We call them the "betwixted" group. They are typically firms that say they want major restructuring of the health care system, but yet they reject the specific reforms we offered them. Obviously, these firms are frustrated with the current system. Their failure to embrace the measures we described, however, could be interpreted a number of ways. They may favor some particular reform not discussed during the interview, or they may simply not know what they want. For example, we neglected to ask about support for a single payer all-government system, yet reportedly many small businesses favor this approach to providing universal access (Edwards et al., 1992). Our omission of this alternative is a limitation of our survey. Also, since the reforms that we did discuss with them could entail eventual costs to either firms or individuals (some nonpecuniary), respondents who perceived these costs might have rejected the measures on that basis. While conceivable, we think this possibility is less likely than the first two mentioned. Nonetheless, we can only speculate on the reasons for this rejection of specific reforms by firms that say they want change.

The opinions of small business on national health care reform have changed profoundly over the past few years. It is no longer true that small businesses are unified in opposition to an all-employer mandate. Today, 42 percent of small businesses agree that employers should be required to contribute to the cost of health insurance for their employees. Yet as recently as 1989, only 24 percent of small business owners lent their support to a statement that employers should be required to provide basic health insurance for their workers (Hall and Kuder, 1990).

The common view that small businesses are unwilling to reduce the current tax subsidy for employer contributions to health insurance is inaccurate as well, based on this survey. Today, only a slim majority believe that maintaining the status quo is the fairest approach to the taxation of health benefits. Forty percent of small business owners either favor a reduction in the current tax subsidy for employer contributions or are undecided on this issue. Among firms that reject the status quo, most believe that a limit should be placed on the amount of employer contributions counted as nontaxable income to employees. They favor a tax cap set at the level of the least costly plan in a firm's local area.

A Heterogeneous Group

This survey also tells us that while their opinions are changing, small businesses today are quite heterogeneous in their attitudes toward health care reform. While there are many firms that endorsed several specific policy

reforms touched on in the survey, there are others that repeatedly rejected the possible reforms described to them, and still other firms that said they wanted major reform but then were unwilling to support specific strategies. In 1993, the first group is by far the largest, comprising 53 percent of all small businesses. Each of the reforms discussed in our survey was endorsed by a majority of these "reformers." In order of preference, reformers favor overall budget limits for health care spending, a mandate that employers contribute toward the cost of health insurance, a HPC system for small business health insurance, and changes in the current tax treatment of employer contributions for health insurance.

The cost of health insurance is an overarching concern of small businesses. Our survey found that cost was the most frequent reason given for not offering coverage, and it was also pivotal in influencing small business owners' support for managed competition. If insurance purchasing cooperatives can deliver savings on the order of 15 percent, then small firms overwhelmingly favor securing workers' coverage through such purchasing arrangements rather than directly providing insurance themselves. Absent such savings, however, only a minority of small businesses endorse the managed competition model. Our survey also suggests that many small firms still don't understand how managed competition would work, so policymakers need to educate this group if they want to elicit their true preferences on this issue.

Small businesses may now be a more potent force for national

health care reform than they were just a few years ago. Not only do firms say they want major restructuring of the health care system, but most are now willing to endorse specific changes in policy. This is new. Although still a collective minority, many small businesses are even willing to support reforms which entail obvious costs to themselves or to their employees.

Small business should not be viewed as a roadblock to reform, but rather as a group that needs to be educated. Our survey shows that when presented with both sides of the case for reform, many businesses are willing to sacrifice for the greater goal of achieving positive change in the system. ☆

Financial support from the Robert Wood Johnson Foundation and the Henry J. Kaiser Family Foundation is gratefully acknowledged. We thank Kevin Haugh and Jeffrey Dwyer for providing useful comments on a preliminary draft of this paper.

References

- Kent C. "Will an Employer Mandate Sink Small Business?" *Medicine and Health* 47 (15) April 12, 1993: 4.
- Congressional Budget Office, *Selected Options for Expanding Health Insurance Coverage*. Washington DC: CBO, July 1991: 28.
- Lippert C and EK Wicks. *Critical Distinctions: How Firms That Offer Health Benefits Differ From Those That Do Not*. Washington DC: Health Insurance Association of America, 1991: 4.
- Lichtenstein J and H Witte, *Government and the Special Circumstances of Small Employers in Rescuing American Health Care: Market Rx's*. Washington DC: The NFIB Foundation, 1991: 43.
- Hall C and J Kuder. *Small Business and Health Care: Results of a Survey*. Washington DC: The NFIB Foundation, 1990: 17 and 37.
- Edwards J, R Blendon, R Leitman, E Morrison, I Morrison, and H Taylor. "Small Business and the National Health Care Reform Debate." *Health Affairs* 11 (1), 1992: 169.

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman. Obviously, we are all trying to understand the President's plan on the basis of the general information that has been put out since we do not have legislative language or a bill. I find it sometimes difficult to understand the more intricate trigger mechanisms, since all of the experts with whom I have consulted say we think it works this way or we think it works that way, but we are not sure because we haven't seen the language.

Dr. O'Keefe, I am sure you have read the 200-plus pages which give us a general description of what the plan looks like. I notice in your testimony that you talked about the things that you liked and some of the things that you didn't like. Interestingly, wouldn't you agree that some of the things that you liked in the plan, such as having health providers organize themselves into systems that merge accountability for service delivery and financial risk are in virtually every plan that has been examined?

Ms. O'KEEFE. As it should be. We recommend it be extended to include the populations most in need of that kind of quality care.

Mr. THOMAS. Once again, when you talk about simplifying the administration of health services virtually every plan has that, and when you talk about universality, everyone basically supports that. The question is, how do you get there. Time is money and how it is structured matters, so in terms of the areas of the Health Security Act about which you spoke glowingly, what I see is that you are basically supporting virtually the universal agreement about the changes that need to be made in the system.

I would like to focus on some of the aspects of the President's plan that aren't universally in all the options, for example, the structure of the National Health Board. With the duties that have been assigned to that Board, how would you describe the powers of the National Health Board as you understand them in terms of setting global budgets and structuring the statutorily set benefits package.

Would you define the National Health Board, as HHS Secretary Shalala did October 5 in front of the Energy and Commerce Committee, as a minor oversight board?

Ms. O'KEEFE. That isn't how we read it in the President's plan as it has been made available, no. It seems to assume a tremendous amount of regulatory and oversight and budget-setting authority. It is mind-boggling to try to picture how it would be implemented.

Mr. THOMAS. So that would be one of your areas of concern, the degree of administrative control and power in the National Health Board, a body described as a minor oversight board by the Secretary of HHS.

You mention the failure to go far enough in terms of malpractice. I am concerned about antitrust as well because those are areas where I think we can get some obvious savings that have been overlooked for a long time.

What is your group's position in terms of a tax cap on deductibility of health benefits? Is that seen as a plus or a minus?

Ms. O'KEEFE. We haven't taken a formal position on that, as a matter of fact. In general, we believe that burden should be shared

between employers and employees. We believe that the financing and the incentives should be restructured to exert competitive pressure in a competitive market for lower cost, higher quality plans. Unfortunately, the solo practice fee-for-service system has been largely responsible for the problems we are in now.

Mr. THOMAS. I understand that. My question is if you want a competitive market don't you have to have something that you bump up against—if you have an open-ended benefits possibility, where is the ability to be competitive within a defined range if you don't have something to bump up against?

Ms. O'KEEFE. We think that there should be some financial incentives on the consumers of health care so they will begin to appreciate the costs of health care and that there are ways to get it more efficiently.

Mr. THOMAS. Mr. Archey, I am concerned about the plan to provide maximum individual incentive which your organization certainly supports along the lines of what is being called a medisave program, in which you basically have a catastrophic medical program, but then, pay for basic health care out of personal dollars that are put into a medical saving account that would accumulate tax free. You could purchase those various incidental items, especially preventive medicine that might be necessary with the hope at the end of the year there would be some left to roll over and use to accumulate an amount of money, and by virtue of the behavior of the individual. Does your organization have a position on that concept?

Mr. ARCHEY. We have not taken a formal position, but our initial look is that we don't think that proposal is going to get you to where you have to be regarding the kind of health care reform that we believe is necessary.

Mr. THOMAS. What about as a component part of a broader package?

Mr. ARCHEY. We would look at that, but I think that our judgment is that the medical IRA ultimately is not going to bring about the kind of universal coverage and the stopping of cost shifting that we would like to see, and number two, a small percentage of people constitute 55 percent of all the health care costs in the country and therefore IRAs for that universe may not work or go far enough. There are a number of other problems we have with a medical IRA that we think it will be found lacking in terms of where we would like to see health care reform go.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. Thank you for your testimony. I particularly appreciate the manner in which you are inviting your members to participate before reaching final conclusions on a specific reform package. This is a complicated area and it really does call for more information being given out, people understanding what the reform is about and taking a look at specific legislation which we still are waiting for.

There is general consensus that we need to accomplish universal coverage, that we must do a better job in the system in bringing down the growth rate of expenses. I want to concentrate on the second.

Both of you have stressed the fact that a competitive environment can help reduce the growth rate of health care expenditures. Dr. O'Keefe, you point to success stories within larger companies in bringing down the growth rates. I must tell you I have some concern as to whether a competitive environment on a long-term basis in health care will be successful in bringing down health care costs.

The President has opted for a system of improving the competitive environment, but having a backup of premium caps to make sure that we do accomplish certain savings in the overall system. My question to you is if the competitive model works, if it is successful in bringing down the growth rate, then what is the danger of having the fall back of the premium caps or some form of discipline on how much we spend? Why won't that type of a model be successful?

Ms. O'KEEFE. I will begin by saying our companies are used to working within budgets. They all have budgets and they seek to stay within them when they provide health benefits for their employees. It gives them something to plan on and something to count on. So in that sense we would find premium caps to be less onerous than say direct controls on prices that are charged for specific procedures, which we have learned in the past create perverse incentives in the system, including increases in the volume of services provided.

Mr. CARDIN. You don't find any problems with at least the philosophical basis which the President is pursuing?

Ms. O'KEEFE. Our member companies haven't taken a formal position on them.

Mr. ARCHEY. Our response would be we see both the philosophical and practical problem with it. I think that it is our judgment that we haven't tried market forces much in this country in this area and that we would like to see that happen before we start to introduce a rather significant bureaucracy that will be involved in assessing and reinforcing a premium cap. There are a lot of things that go with a premium cap that we don't like.

Furthermore, we are concerned even with some of the caveats you suggested that premium caps end up basically putting in place inefficiencies and regional variations that even Mrs. Clinton a couple of weeks noted the distinction between Boston and New Haven and the considerable difference in health care costs without any necessary aid to health itself. So that is a concern of ours.

Mr. CARDIN. I read that in your prepared statement. My point is that we don't know the details yet. I share your concern as to how you allocate resources within premium caps and how you deal with regional variances, and how you avoid penalizing States or regions that have been aggressive in keeping costs down with the same overall growth limits. I understand those practical problems.

Putting those aside, if we establish the competitive environment that we are all striving toward, what is the danger of having the fall back of the premium caps to make sure in fact we accomplish the goals that we have set out in national legislation?

Mr. ARCHEY. I think this is a tough one because it is still fairly speculative as to how some of this will work. I think fall back becomes—not fall back. It becomes the expectation that that is what will be there.

Mr. CARDIN. Then in reality maybe the competitive environment can work. If you can't work within that budget, if it is not going to produce the type of competitive pricing that you would like to see, if the cap becomes the floor, then in reality we should go to budgeting rather than even trying the competitive model if it can't work.

Mr. ARCHEY. I think we are arguing what might happen and what we would like to see happen first is an attempt at trying market competition particularly through the HIPC system that is particularly the one that is laid out in the plan that Mr. Grandy, Mr. Cooper, and others are involved with before we start emphasizing the notion of having a premium cap.

We think let's keep that not only on the back burner, but on the profoundly back burner, way back there. What we would like to see is an attempt to go after some notion that real competition with leverage on the part of some of the buyers can work. And that it, in turn, can have an impact in the provider community.

I would agree with your concern about whether or not it is going to work, but I would like to see it and my institution would like to see it tried first before we start emphasizing the issue of premium caps.

Mr. CARDIN. Many of us think we have tried that for many years in many parts of our country.

Mr. ARCHEY. I don't think so.

Mr. CARDIN. Thank you.

Chairman STARK. Well, let me try. I have just raised a question, Dr. O'Keefe. I have a draft of a GAO report that was prepared for me at my request some time back and the gist of it is that there is no evidence that managed care really does save much money.

They suggest things like the fact that younger, healthier employers will go into the PPO system where the smarter, sicker, older folks will stay in fee-for-service because they know they can get to the teaching hospitals which they can't under PPOs. They suggest that for instance nobody has really studied under a limited access plan like a PPO or an IPA-type HMO. If you had studied what the same costs to the same population and the same market might have been had they been treated in fee-for-service, again, they suggest there is very little evidence that these various systems provide savings.

Now, there may be and my hope would be that the people who feel that they have saved some money would come up with some more empirical evidence. The only other thing that I would add to confuse this is a huge insurance study which suggests that over the 10 year period of 1981 to 1991, Medicare per capita expenditures increased by 50 percent, and premiums in the mid to large employer group increased by 97½ percent, and nationally per capita expenditures went up 55 percent.

Now, a lot of that might be attributed to the fact that many employers' benefits were far more generous, although in recent years most employers have been reducing benefits as a method of cost containment rather than increasing them. But I would hope, because sooner or later we are going to have to add up numbers, that your group is prepared to address this issue because I am certainly going to ask the GAO to finish working on this draft and see

whether they can in fact get us some empirical evidence because that might be of some concern when we try to figure out what we are going to pay for.

Mr. Archey, I have two issues that I would like to cover with you. One, I have often quoted the NFIB survey of small businesses that suggests that in a question asked of their membership, would they favor providing health insurance to their employees even if they had to pay none of the cost, and those people with great sense of social justice, 58 percent said, no. I don't know quite how we are going to deal with them because if we gave it to them free they indicate they are not going to help their employees under any circumstances.

I think that question reflects an abiding dislike, distrust and aversion to anything remotely governmental. I would ascribe it not to an indication that they are indifferent to the welfare of their employees, but mostly to this kind of frontierlike mentality that might be evidenced by these entrepreneurs.

I don't know how we are going to deal with that. But I did want to suggest to you, after looking at the President's plan and the 3.5 percent premium on wages for small business, although I must say that 3.5 percent has slipped away in recent days to be a sliding scale. Nonetheless, let's take 3.5 percent of a \$6 minimum wage is 21 cents an hour.

I doubt if there are many people in the food service or the hospitality business who pay their basic employees much more than that. The rest is tips or the fact that there is no union representing them so they never get much above \$6 an hour. I can't believe that a business could be so marginal, whether it is a McDonalds, a bar, or a motel, that they are going to go out of business if everybody in town pays an extra 21 cents an hour. Particularly if you look at the evidence of the last four increases in the minimum wage, the evidence shows there was an increase of jobs saved for the times when we had a 10-point increase in the minimum wage. For each 10 points there was about a 1 percent drop in teenage, 18 and under employment only.

I have always said that that is a risk in the employment rate of those 18 and under and I am willing to accept that for the kids if we get full health insurance coverage for them. What can you suggest we can do to take on this very vocal yet somewhat parsimonious group to convince them that coming up with that 2 pennies an hour might be the right thing for them to do? How can we sell them?

Mr. ARCHEY. I think it is important to note that the Chamber's position on health care reform is we are genuinely trying to solve this problem.

Chairman STARK. I know that.

Mr. ARCHEY. We are not trying to sell memberships and I can't say that strongly enough. Point 2 is that given the survey that I gave you and some other stuff that is starting to come out, the notion that there is a monolithic view on the part of small business about health care reform is absolutely wrong, and I think people who assume that it is will be greatly misled.

Point 3, how do you know what your small business members know when they don't know what is in these proposals? You have to in fact provide the stuff.

Point 4, if you look at the subsidies, we ran numbers that are going to be the subject of a cover story in Nation's Business Magazine this month, the November issue, by a very competent reporter, Roger Thompson. He looked at four different examples. One example closely comports with what you are saying. Average wage of \$12,000, which is close to pretty much the maximum subsidy, you are talking about an increase of \$1.25 a day per employee under that proposal.

Our concern, for a company that is currently providing some form of health insurance and is yet eligible for the subsidy in terms of \$24,000 average wage or less, less than 50 employees, this is a good deal. The question is going to be over the longer term is this a permanent entitlement, is this going to be something that is going to have to be budgeted? We haven't made a judgment on that.

Chairman STARK. In every other country in the world, First World, Second World, Third World, health care is an entitlement. Will health care become an entitlement for every American? That is what the President is saying, that we must guarantee access to coverage to every citizen in this country. It is not an entitlement; it ought to be. I think it ought to be a constitutional right, but that is a matter of some difference. But I would not want you to think that anybody is trying to kid you that health care for every American would not in time become an entitlement. I think we would be shamming you if we said otherwise.

My time is up. Mrs. Johnson.

Mrs. JOHNSON of Connecticut. Thank you, Mr. Chairman. My questions follow on some of the questions raised by my colleagues earlier in this hearing but to a different aspect of them. Both of you have supported the reorganization of the delivery system and I strongly support that. I think that is where the big cost control is going to come.

The issue is how we achieve that? In looking at how do we achieve that, I want to talk about two issues, one, the "payrolltizing" of health care costs and the implications of that and the difference between the premium cap and limiting tax deductibility as different mechanisms to create a competitive market.

As to the first one, the payrolltizing of health care costs, Dr. O'Keefe you have attested to the incredible effect that business has had on cost control through their own initiatives and you want to spread that. Now, if we turn health care costs into a fixed business cost, then none of those companies that have shown so much leadership, creativity, aggressiveness, tenacity and dedication will have any motivation to continue to do so.

In fact, the companies that have done the most to control health care costs will pay exactly the same tax as the companies that have done the least. I think that will sever private sector involvement in the national challenge to control health care costs.

If you look at government's role in health care cost control, we have had the right to encourage managed competition or managed care or the reorganization of the delivery system in both Medicaid

and Medicare and we have not been willing to do it in the face of the overwhelming evidence that it both reduces costs and increases quality. So the issue of the payroll tax is not only a big issue because if the administration estimates are off, that payroll tax will go up rapidly; so companies ought to think do we want a payroll tax, not do we want 7.9 percent of payroll to go to health care. Because if Social Security is any model and our experience with health care cost increases when the government rides herd on them is any indication, that 7.9 percent, that 3.5 percent will double and triple. So the larger issue is not the level of the tax. The larger issue is what are the consequences in a free, competitive, market-based economy for turning over the challenge of cost control in the private sector to the public sector, and that is what the President's proposal does.

I think you as business groups with your experience in what the private sector has contributed to cost control need to comment on what will be the motivation after the payrolltizing of health care costs for business to continue to press on the issue of cost control.

Ms. O'KEEFE. I think that is exactly the point.

May I clarify for the chairman and other members what the Washington Business Group means by managed care? It is a term that means different things to many people. To some it means a clerk working for an insurance company someplace remote from the site of service delivery denying coverage for benefits. That is not what we mean by managed care. We mean actively working with the total system, looking at the outcomes, developing measures to assess quality and outcomes and basing treatment decisions on that information. So we are not nearly as interested in, for example, defining the specific benefits for mental health as we are in assuring that mental health care be delivered in a managed care setting which will incorporate the fiscal and outcome responsibilities. Under those conditions, you will get good care at the best price.

I agree that it would be naive to presume continued active involvement on behalf of our large employers to shape the care their employees receive if there is no incentive for them to do so.

Mr. ARCHEY. I think you are making a number of points and I think to some degree we share that concern. You call it payrolltizing, the concern that there may be no incentive if they are capped at 7.9 percent. I think that is a concern we have and one that we have registered.

Your second point is one I would like to go back to what Mr. Stark said earlier, the managed care. I think we are getting increasing anecdotal evidence that there have been very salutary outcomes in the last 2 years in terms of companies that have been at managed care for some time because the companies got more sophisticated. There is managed care and then there is managed care.

We have a member company that we were talking to yesterday that in the last year had a 3-percent decline in their health care costs as a result of the managed care program, and another we talked to that was even with last year.

One thing we are very concerned about is that some of the experience of some of the larger companies with good well-managed,

managed care programs, that those experiences not get lost in the whole transformation, if you will, of the health care system.

Mrs. JOHNSON of Connecticut. May I have a followup question or wait until later?

Chairman STARK. We will go around and go around a second time. Doctor McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman. Dr. O'Keefe, you began by saying that delivery system is the problem and I think that in this debate there needs to be some clarification about what people are intending to change.

Are you intending to change the delivery system or the financing system? I want to talk about the financing system, because it seems to me one of the biggest problems is the area of cost shifting. Do you think universal coverage is essential to health care cost reduction for big business?

Ms. O'KEEFE. Yes, I think it is essential to health care cost control for everyone.

Mr. MCDERMOTT. So you would reject any plan that does not guarantee universal coverage, not offer universal coverage, but guarantee it—you would reject anyone that didn't get universal coverage?

Ms. O'KEEFE. I don't have that mandate from my employers. They want us to get to universal coverage. I think they would differ greatly on how fast and how the system should be designed to get there.

Mr. MCDERMOTT. So they are willing to accept continued cost shifting from the government side on to the private sector?

Ms. O'KEEFE. No they are not happy with that.

Mr. MCDERMOTT. I didn't say they were happy. They are willing to accept it until the year 2000, to gradually phase it in and continue us shifting Medicare costs on to the private sector? Is that what they have said?

Ms. O'KEEFE. No. They have said that by the year 2000 they want universal coverage.

Mr. MCDERMOTT. So for 7 years they are willing to accept cost shifting.

Mr. Archey.

Mr. ARCHEY. I guess 6 or 7 months ago the Chamber surprised every one when we came out with the notion of universal coverage accompanied by the concept of shared responsibility that is, that government, employers and individuals would all have to contribute something to it. That is still our position. We have never put it in the negative. Would we oppose ultimately a program that didn't have it. Our position right now stated in the positive is quite clear. We want universal coverage and think that you can only end cost shifting if you have universal coverage.

Mr. MCDERMOTT. It seems to me, then, you almost have to have the negative. You have to be willing to oppose anything that doesn't guarantee universal coverage. I don't know how you get logically out of that position.

Let me ask another question. Are your members willing to forgo the administrative savings to business that eliminating multiple payers would yield? GAO did a study saying you could save \$70 billion. Mr. Magaziner says his program saves \$7 billion on adminis-

tration. You are willing to forgo \$63 billion in administrative savings by keeping multiple payers.

Ms. O'KEEFE. Our members believe that multiple purchasers are necessary to achieve the end goal of cost savings. Restructuring the delivery of care into organized systems of care and holding them accountable will achieve much of the same savings by organizing our currently fragmented system. The problem with the President's plan as proposed is that it requires practically everyone to be in the regional alliances. By the administration's accounting, their proposal would leave only 12 percent of working Americans outside of the huge regional alliances would function as nearly monopsonistic purchasers.

One of the reasons that our employers have gotten good at this is that they know their employees. They have a captive audience. Consumer education, health promotion and wellness programs are important parts of this and basing those at the work site has proven to be very effective. Our employers are asking to continue playing that role for their employees. They have the market clout currently, which they might not have in the new system, to network providers into organized systems, and to work with those health systems to achieve the ultimate goal—which we certainly share with the U.S. Government—a healthy, happy work force.

Mr. McDERMOTT. Mr. Archey.

Mr. ARCHEY. We think that there is going to be administrative saving and serious consolidation in the health insurance industry as this thing proceeds along. Our preference is still the multiple payer model, and we don't think that it excludes a large amount of savings that can proceed from simplification within a multiple payer system.

Mr. McDERMOTT. Let me ask you another straightforward question. I think a yes or no might work. Your opposition to the fee-for-service system is based on an open-ended system that we have today, no end to it. If you apply capitated budget limits to the fee-for-service systems the whole basis of your objection disappears, right?

Ms. O'KEEFE. No. Our basis of objection to the fee-for-service system is that it provides uncoordinated unmanaged care and in many cases creates more health problems for the individual consumer who is in that system and who, by default, must be in charge of managing his own care.

Now, individual consumers just aren't in the position to know what is available and what is best for every medical problem. We endorse increasing the number of primary care providers who can serve in this management role. But a lot of the problems that people get into in fee-for-service is getting the wrong care, the wrong kinds of treatment and multiple treatments which in the end hurt them more than help.

Mr. McDERMOTT. Do you put any value on the doctor-patient relationship?

Ms. O'KEEFE. Absolutely.

Mr. McDERMOTT. Yet you think everybody should be forced into a managed care situation where they may not be able to see one of the two or three, the practitioners that their family is accustomed to seeing?

Ms. O'KEEFE. No. We don't believe in forcing anybody into anything. As a matter of fact, our employers have spent a lot of time and money educating their employees about the value of this kind care. When they do and when they continuously measure consumer satisfaction, they discover that providers are getting very good marks in these systems.

Mr. McDERMOTT. Thank you, Mr. Chairman.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Thank you. By the way, I think there is a straightforward answer to my colleague Jim McDermott's as usual perceptive question about continuing to tolerate cost shifting for a period of years. There is a willingness to tolerate that in the President's approach. Any transitional provision has some tradeoffs by definition. So I think the straightforward answer to you is, yes.

Mr. McDERMOTT. If the gentleman would yield, there are some proposals on the table now that do not guarantee universal coverage. They offer the opportunity to buy but they do not guarantee that people will be able to pay for it and get the coverage.

Mr. LEVIN. That isn't transition, though. That is—I would say that is potentially so. There is no assurance. It is different where you insure, though you phase it in. Let me ask a couple of questions and the spirit of them, I think, is clear, the spirit with which we all ask questions. Indeed, I think we have been struck by the constructive approaches of both your organizations so let me ask a few probing questions.

Mr. Archey, you attack any kind of caps and you say we are wary of counting our chickens before they hatch. How do you answer the argument that when you have no fallback provisions of any kind you are diminishing the chances that the chickens will ever hatch? Also, you talk early on about your concern about overestimates of cost savings. However, if you remove the caps altogether, won't the likely savings be even more ephemeral or less easy to calculate?

It seems to me there is a real tension in your position. Don't count the chickens before they hatch, but don't do anything that allows us to be at all certain that we will see any hatching at all.

Mr. ARCHEY. I think at this point in the health care reform debate, and it is not going to be restricted to this, there is going to be a lot of tension in our positions on this and several other issues. I think that part of our position on the caps is partly philosophical in terms of whether or not we ought to be entering into the marketplace when this probably is the first full-fledged attempt to try to bring some market competition into this system.

Second, there are other ways to do some of these things, one of which perhaps might be, on some of the subsidies that are inherent in the President's proposal, is to budget those subsidies, probably index them for inflation and bring a little rhyme and reason on that side. We don't think that as the last resort or the first resort that premium caps ought to be at the top of the list.

Mr. LEVIN. I don't think it is fair to characterize them that way, because I don't think that is intended by the President. Let me just quickly so we—

Mr. ARCHEY. In the draft of the President's proposal, the way it is at least enunciated, I would submit that the premium cap issue is fairly foremost in that proposal.

Mr. LEVIN. At least you've qualified it and said fairly foremost. I don't read it that way.

Let me mention a second point of tension that relates to choice. You very much come from a school and from a background where consumer choice is important. Yet in your testimony in a number of places you seem to be moving in a direction which would diminish choice. For example, on page 5 you said a major reason you want to peg the employer contribution lower is to encourage consumers to choose less expensive plans. Then, as people reach Medicare eligibility, you want them to remain in the existing care networks rather than transferring to an artificially preserved fee-for-service environment.

Mr. ARCHEY. Let me—

Mr. LEVIN. How much choice are you willing—

Mr. ARCHEY. A lot. We are willing to provide a lot of choice. We are saying that the consumer ought to have the opportunity to weigh a number of different choices out in the marketplace and through the HIPCs we think that that possibility could be enhanced rather than diminished.

The second point I think that we make in terms of what you are saying about consumers not maybe being more cost-effective, we are not at all in favor of limiting an individual or an employee's right to get a more expensive or more comprehensive plan. We are saying pay for it and in fact that becomes taxable benefit.

Mr. LEVIN. How much are you willing to load the scale for one type of care against another? Would it be loaded against fee-for-service? How much—give me some rough approximation—how much of an inducement, incentive, stimulus would you use? Pegging it at the lower third or half of plans is a pretty heavy weight on that scale, isn't it? This is an important question, I think. How much would you load the scale in favor of stimulating people to go away from fee-for-service programs?

Mr. ARCHEY. I can't answer that question. It is just not one—in the way that you have addressed it, I don't know. We are not opposed to fee-for-service plans if in fact they are competitive. We are not suggesting that fee-for-service plans be eliminated and there is nothing in our positions that would indicate that.

Mr. LEVIN. Thank you.

Chairman STARK. I didn't mean to allow Mr. Levin to go over time, but he hid my gavel.

Mr. LEVIN. Not on purpose.

Chairman STARK. Mr. Grandy.

Mr. GRANDY. Thank you, Mr. Chairman. Let me ask this at the outset. The chairman was referring to a GAO study about whether or not managed care really means savings and I think one of the debates in this committee, one of the ongoing problems with determining what assumptions are correct in health care policy, will kind of vacillate between supposedly scholarly evidence prepared by GAO—although I think that is probably giving them too much credit—and anecdotal evidence about various managed care or management competition systems around the United States.

I might point out for the record that anecdotal evidence was supplied to this committee last week by the First Lady when she was defending the administration package and used Minnesota, Califor-

nia and Rochester, New York, which I would have to believe are three of the managed competition and managed care success stories in the United States. I think that is worth putting on the table as to whether or not anecdotal or scholarly evidence is going to prevail here. I think we won't know until we try some of these systems on a larger scale.

Having said that, Mr. Archey, yesterday when the Managed Competition Act was introduced with 29 Democrats and 22 Republicans, the Chamber said in a letter:

Particularly given its bipartisan support this proposal must be given serious weight as the debate proceeds in Congress and the public strives to reach consensus.

I take that to be an endorsement of the process and not the product. Is that the Chamber's position?

Mr. ARCHEY. Yes.

Mr. GRANDY. You said you have likes and dislikes about this particular piece of legislation and I think your position on the administration's plan, your likes and dislikes, have been fairly well stated, and I think it is clear what your feeling is about a single-payer system.

Could you quickly give us what you consider to be the strong likes and dislikes in the Managed Competition Act that was introduced yesterday?

Mr. ARCHEY. I will do it very quickly. We like the way that you construct both the way the HIPC's work and their size.

Mr. GRANDY. Do you agree with Dr. O'Keefe that 100 is about the right area—

Mr. ARCHEY. That is our position. We like the fact that in the Managed Competition Act of 1993 there is much less emphasis on Federal bureaucracy or State bureaucracy. We like the fact that there are no targets that are imposed by a National Health Board on the various regional alliances. One of our real concerns with the Clinton plan is that on the issue of malpractice reform we think it fails to go far enough. Some would argue whether or not it really is malpractice reform or just a bit of window dressing. So in terms of what you are proposing in the Managed Competition Act, we like that.

We like the fact that the act basically emphasizes the commonality of programs among the States rather than deviation, which is another of the real concerns we have about the Clinton program.

We are very concerned about the Managed Competition Act of 1993 because, to go back to Mr. McDermott's point, it does not offer universal coverage. It does not require universal coverage. We think that is essential in terms of the cost shifting argument.

Mr. GRANDY. Would you then advocate some kind of individual mandate to require insurance?

Mr. ARCHEY. Our position is the position of shared responsibility in which, if you will, everyone has got to do something in terms of making a contribution. And the other point I think that we are concerned about is we do not like the idea that if an employer goes the average plan, or that is not the term your bill uses, but within a given HIPC, providing a plan above the average to its employees means the employer loses deductibility. That is of great concern to us. That is fairly quick off the top of my head.

Mr. GRANDY. Dr. O'Keefe, what was the basis of your organization choosing 100 employees as a workable threshold below which a marketplace discipline would be imposed on small employers? Why not, for example, 5,000 that the Clinton administration proposes or 1,000 which was the old conservative Democratic forum's proposal of last year?

Ms. O'KEEFE. The basis is philosophical and demographic and practical. At 100 or below, there is an argument for needing to pool to garner sufficient purchasing power to do the kind of serious negotiations that would result in forming these good partnerships. Philosophically, my group has long watched the developments of the Jackson Hole group where these ideas began to germinate. Jackson Hole has argued for a threshold of 100. Demographically, there isn't much rationale for going about that. Insurance companies stop experience rating after a fairly low threshold because beyond that it doesn't net them anything. Beyond that point they begin to community rate groups.

Mr. GRANDY. Are you saying that the problem of adverse selection and risk adjustment is less above a hundred than it is below—

Ms. O'KEEFE. That is right.

Mr. GRANDY. Does the Chamber concur with that, Mr. Archey?

Mr. ARCHEY. Yes.

Mr. GRANDY. Thank you, Mr. Chairman.

Chairman STARK. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman.

Mr. Archey, it is great to be for a lot of general things like universal coverage, but I don't see in your testimony any specifics as to how you would achieve universal coverage. You gave us a statistic, regarding 55 percent of the costs of the health care system. What was that statistic you gave us?

Mr. ARCHEY. It is that a very small percentage of the population constitutes 55 percent of the health care costs, 4 percent.

Mr. MCCRERY. Is it true that the great majority of that 4 percent are elderly?

Mr. ARCHEY. Not necessarily I don't think.

Ms. O'KEEFE. That 4 percent represents individuals with chronic diseases, catastrophic illnesses, and the terminal ill. A lot of money in the current health care system is spent on people in their last year of life.

Mr. MCCRERY. What would you do with Medicare, for example? Would you leave it alone, would you include it in some universal system?

Mr. ARCHEY. Our position is that Medicare should remain outside of the regional alliances at this point in time. Medicaid should be brought in.

Mr. MCCRERY. So cost shifting from the public to the private is OK, but cost shifting within the private sphere is not OK?

Mr. ARCHEY. No. Our view is you bring Medicare in over time, but you can't do that in one fell swoop. No. 2 is you bring a lot of the changes in terms of managed care and other aspects into the Medicare system in a much more aggressive way. We have as much concern as you do. The reason the Chamber has taken the position on universal coverage, which was a tough position to take, and on

the issue of shared responsibility, was primarily because of cost shifting.

This is an issue that is of enormous concern to our membership, small, medium and large.

Mr. MCCRERY. Universal coverage, again, is a great goal. I am going to try to get people to be honest and straightforward about how to achieve that. Mr. McDermott and Mr. Stark and others who favor a single payer are honest. They want the taxpayers to pay for a single-payer system to provide coverage for everybody.

The Clinton plan is basically straightforward, although their numbers are a little fuzzy. At least they say somehow we are going to finance universal coverage with taxes primarily, and with an employer mandate. You are for an employer mandate, but you don't tell us how you would fill in the gaps. I assume that you would favor some tax to achieve universal coverage if there is going to be this shared responsibility, is that right?

Mr. ARCHEY. We have not made the judgment on whether it will be a tax or the specific tax it would be. We have judged that if you do not have universal coverage the cost ultimately to society because of the cost shifting and because of the costs that would be incurred will probably be greater than whatever it will take to make universal coverage a reality.

Mr. MCCRERY. If you have universal coverage through whatever means how do you plan to prevent overutilization, which we have now to a certain extent because of the third party payment system that dominates our system?

Mr. ARCHEY. I think there are a number of things that are not exclusive to any of the major proposals now. One thing we are looking to do is the question of protocols for doctors, what are the practices that ought to be followed. I think that there are a number of disciplines that have been introduced already through some of the HMO experiences that I think will be transferable in terms of not overutilizing the system and not having providers overuse the system.

On the other hand, the providers also have to have some room to maneuver regarding the possibility of malpractice because of the fact they didn't provide certain tests, et cetera. Any plan that we want to see happen is going to have to include this. So there are a number of things—I would defer to Anne Marie, who comes directly from that group in terms of additional ideas.

Ms. O'KEEFE. I would like to emphasize that we consider the problems of utilization and the issue of choice to be different whether you are talking about an uncoordinated fee-for-service system where consumers must manage their own care, or an organized system of care where services are managed and coordinated by medical professionals. Within an organized system of care or an accountable health plan, which unites financial responsibility with the responsibility for the outcome of care, you don't have the incentives for overutilization of inappropriate services.

Within an accountable health system, choice also becomes meaningful. It is an important issue for Americans, but the practical fact of the matter is if an individual is out there on his own choosing what providers to go to, he has maximum choice, but it is not necessarily well-informed. An individual consumer isn't prepared at a

moment of medical emergency or any other time to check and verify the credentials of any individual provider. A system is.

A system would be responsible not only for the credentials, but for the quality of work provided by every practitioner within the system, which is again why enterprise medical malpractice liability makes sense to us.

Mr. McCRERY. Mr. Chairman, I will return in a minute to ask some more questions perhaps of later panels. But basically I disagree with your contention that individuals are not responsible enough to take care of themselves.

Ms. O'KEEFE. I didn't mean to imply they aren't responsible. They are ultimately responsible. But they don't have access to the kind of information necessary for them to make informed choices among providers and services.

Mr. McCRERY. Thank you.

Chairman STARK. We will run around a second time here. Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

To take off on my friend from Louisiana's comments, I think that is one of the reasons that you were unwilling to bite on the \$63 billion in savings of the single-payer system. I think you would say that \$63 billion in a \$1 trillion market that would truly utilize proven market controls on cost is not peanuts, but it is not the kind of money you want to go for compared to the savings you could get if you had informed consumers. That is the key, with a computerized structure on outcomes, procedures—

Ms. O'KEEFE. Integrated medical records.

Mr. THOMAS. Any structure that would deliver those changes in a way doctors would accept it, and therefore implement it in the system with informed consumers making rational, individual choices on health care options, we are willing to bet that it will save far more than the \$63 billion in the administrative costs that a monolithic, bureaucratic, dictatorial system, which he is advocating the single-system payer would save. Is that a fair statement as to why you would be opposed to the tantalizing \$63 billion savings in a single-payer system.

Ms. O'KEEFE. We also want to be sure that we structure a system that produces continuing quality improvement and continued savings. Those one-time, high-ticket savings are very alluring, but where will we be in 5 years?

Mr. THOMAS. The key to that is I think an informed consumer having the freedom to make those choices in a structured marketplace that is going to be competitive.

Mr. Archey, do you have comments on that?

Mr. ARCHHEY. I think that we very much emphasize the issue of choice in our proposal within the concepts of regional alliances or HIPCs. I think we are on the same wavelength with you on that.

Mr. THOMAS. Regarding HIPCs, I am trying to recall what you said earlier. Do you believe they need to be mandated or can they be optional, the HIPCs or the alliances?

Mr. ARCHHEY. We would like the purchasing cooperatives run as a cooperative the way I think Mr. Grandy's bill does.

Mr. THOMAS. One of the primary reasons would be to enjoy the economies of scale.

Mr. ARCHEY. With particular emphasis to giving some of that leverage to small firms who currently don't have it.

Mr. THOMAS. Here is my problem with that concept, and we get into these debates about the shape of the alliance; everyone disagrees with the enormous bureaucratic powers the Clinton plan would give to alliances and the National Health Board in trying to make it work.

If you have a mandated benefit plan and if you are espousing universal coverage on insurance and changes in the insurance industry, and you have an understanding of what that plan is going to cost, why do you need to construct these massive cooperatives and even mandate them with this fundamental change in the structure. As the First Lady said, our benefit plan is kind of a composite of the Fortune 500 model.

Why can't you take a composite of that cost and indicate to insurance companies that this is the targeted price. It is printed on the business pages as to what that amount is for the plan and it is up to insurance companies to try to figure out a way to deliver that plan through an organizational savings of either voluntary cooperatives or administration changes so that you don't have to have this mandated cooperative structure moving from group coverage to individual coverage, which I think is a massive shift. It is open-ended.

Mr. ARCHEY. The problem is there is already existent, and I don't think it will go away for a long time, tremendous regional variation in terms of health care costs, in terms of the actual cost of delivery, the cost of getting the health care and the health care insurance. That is No. 1. No. 2, I guess we are saying we like very much the idea of bringing these decisions down as close to the local level and to people there on the ground as you can possibly get it.

We think that the health insurance purchasing cooperative is a very good way to do it. It allows for local experimentation. We obviously want to see certain national requirements, but we would like to see some local option.

Mr. THOMAS. But your problem in terms of pricing is a problem that the HIPC will have anyway. That is a common problem. I am bringing it down to the local firm who looks at the price and turns to his insurance company and says this is what is currently being charged, paid for by the larger companies. I want you to deliver that to me. With the clear incentive that the insurance company is going to have to do it, we are making every small employer their own HIPC. I think that brings it far closer to home.

Mr. ARCHEY. You are suggesting a one-stop shop approach.

Mr. THOMAS. No, I am suggesting that if you are using the Fortune 500 as a kind of criteria on what the benefit plan is, why not use the price of that benefit plan as the cost driving mechanism in the marketplace instead of restructuring the whole world along the mandatory cooperative, which moves everybody from what largely now is group insurance to individual.

Mr. ARCHEY. We would like to look at that proposal and pursue it further.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON of Connecticut. For the record, there has been a lot of discussion of the \$63 billion in administrative savings that

a single-payer system would generate. The same GAO report that estimates that savings also estimates that a single-payer system would increase costs \$70 billion by allowing a new demand for services. So I think we have to be very careful in looking at that \$63 billion savings, because behind it would have to come heavy micromanaging to avoid the additional \$70 billion in increased costs, and it is in the same report. So I invite you to examine it.

Second, I think it ought to be clear that the administration plan, and this is matter of testimony, preserves the cost shifting currently in the system between public and private reimbursement rates and does not seek to increase public reimbursement rates or even bring them up to the level of the premium set by the health alliances. It also allows two additional cost shifts.

I would like you to do some research on this and get back to us. By including retiree health benefits some companies' costs will decline, other companies' cost will go up because the system costs will go up. That is a shift of costs that I think we need to look at.

Second, by allowing companies that have a benefit plan richer than the benefit plan of the health alliance to continue to get full deductibility for that benefit plan, there will be a cost shift from the companies with richer plans to companies with the premium capped plan. I think at least I would like some help in analyzing that shift and what it is going to amount to and how much is the relief given to certain companies with very large plans and very big obligations going to cost the rest of the business community and particularly the small business sector.

The issue I want to raise following on my discussion of payrolltizing insurance costs is the issue of the merits of backstopping cost control with a premium cap versus deductibility.

Mr. Archey, you mentioned you don't like the idea in the Cooper bill, that companies would not get the incremental deductibility between their rich plan and the lowest cost plan. As one who is an advocate of the three or five lowest cost plans, I don't want to have this too rigid a discussion, but it looks to me that capping deductibility to some average toward the low end of the market allows a very strong competitive market whose goal it is to produce quality care for that lower range cost.

And if we don't, in a sense, penalize companies that have first-dollar coverage and Cadillac plans by at least not allowing them to deduct the marginal difference between that lower amount and their top dollar amount, then we will not drive the reorganization of the market into lower cost systems of care as aggressively as we must to control cost.

In contrast, the administration wants to backstop the system with premiums negotiated by the alliances, but the premiums negotiated by the alliances will be backstopped by the global budget. If the estimates for cost control don't come through, that global budget will trigger in right away and the premiums will not be a negotiated agreement about the cost of these services, but a negotiation that involves how much the premium has to be in order to meet the global budget targets.

That is the way Medicare works now. This is not a concept or a system that we don't have experience with. Medicare rates now are set as to what we think the health care costs involved would

make those rates and then they are arbitrarily adjusted downward to take into account the volume factor and meet the global targets. That is reality.

We, right now, in the whole Medicaid program set rates for hundreds and hundreds of procedures and office visits and then we say this is the rate it should be if you are going to talk about what the cost of care is, but this is the rate it is going to be in order to meet a global target. That is going to be fundamentally the system in the premium caps with a global budget.

If you look at that as a very arbitrary and inflexible mechanism for cost control versus tax deductibility, which assures a competitive market, because if your premiums aren't right you aren't going to get a competitive market. You will get fewer and fewer companies in the market, and you are going to get more and more ways around the barn to pretend to provide care for a premium that doesn't cover costs. So I want to hear your thoughts on these two different mechanisms of backstopping cost controlling, in writing—I want to lay out—this is a challenge that we all face.

I think tax deductibility is far more flexible and offers us some real effort to press reorganization more rapidly in the right direction.

Mr. ARCHEY. We will put it in writing. I don't think we disagree about where we want to end up. We do not think that putting that burden on the employer by removing the tax deductibility is necessarily the way to go. We also think when you get above a particular plan that the consumer, the individual himself perhaps ought to be looking at the contribution for that. Again, I don't think we disagree with you about the concern that you raise.

Chairman STARK. Other members.

Mr. GRANDY. I would just like to point out that in that question Mrs. Johnson has entered the Guinness Book of World Records for the longest question, breaking her own record set just last week.

I wanted to just make sure that I understood when you answered the question about what you call the deductibility problem with the Managed Competition Act. The Chamber is not philosophically opposed to a limitation on deductibility. It is with the specific proposal in the Managed Competition Act which limits it to the lowest cost accountable health plan in the region; is that correct?

Mr. ARCHEY. We understand what your proposal does and we understand when you will kick in the exclusion of the tax deductibility, but we still don't like it.

Mr. GRANDY. Are you opposing limiting deductibility on its face or opposing our proposal in that area?

Mr. ARCHEY. We are opposed to limiting employer deductibility in any way on this issue.

Mr. GRANDY. Do you favor the proposal in the Clinton plan to extend the 10-year grace period to large employers—Fortune 500 companies—to 10 years so that they can continue their Cadillac plans while the rest of the system is basically trying to contain costs?

Mr. ARCHEY. We can look at that. The other half of our position on this is perhaps not the most politically attractive one, that if an employee opts to buy a Cadillac plan, beyond the average or na-

tional plan, that becomes a taxable benefit to the employee. So we are not saying that there shouldn't be some incentive brought in.

Our difference is we are saying the incentive ought to be in terms of being more cost-effective, cost conscious, et cetera, on the part of the employee.

Mr. GRANDY. Wait a minute. You are saying that if the employee were to buy a more generous plan than anything over the deductible limit should be treated as taxable income, it should be a taxable benefit? You just don't like the burden falling disproportionately on the employer.

In other words, if the employer provides a more generous plan, the Managed Competition Act says anything above that is going to be taxed. It will, however, be deductible by the employee and it won't be considered as income. You want to even that out?

Mr. ARCHEY. Correct.

Mr. GRANDY. Both of you have said Medicare must be included in health care reform and that is one area where all plans are cautious to the point of being coy about dealing with Medicare. The President's plan expands benefits for Medicare while taking \$125 billion out of the provider reimbursement.

In our bill we try and create an incentive for a Medicare buy out by telling beneficiaries if they go into some kind of accountable health plan they will be able to acquire a prescription drug benefit. What are your thoughts on how to incorporate the 33 to 36 million people into a unified health reform plan?

Ms. O'KEEFE. We heartily endorse your approach. One of the ways well-managed organized systems of care attract Medicare beneficiaries right now is by offering a prescription drug benefit which is not covered under Medicare. We hoped these incentives would be included in reform proposals to induce a further migration into these accountable health plans where Medicare beneficiaries have been pleased with their care. We would have given them an inducement by structuring better benefits inside organized systems, not be adding them to the current Medicare system.

Mr. ARCHEY. I would subscribe to what Anne Marie just said.

Mr. GRANDY. You would be favorably disposed toward some kind of incentive to lure people from Medicare into a system and keep them there even if it meant discarding, generally, a fee-for-service plan and entering a more managed care kind of model?

Mr. ARCHEY. Yes, sir.

Mr. GRANDY. Thank you both.

Mr. McDERMOTT. Mr. Chairman, I am sorry I was out of the room when Mrs. Johnson raised the question of the CBO study. The CBO study says that in fact a single payer system would increase health care spending by 5 percent, without single-payer health care costs would increase by 11 percent so it is half the rate of growth of our current system. What she did not say is that the single-payer system savings over the next 5 years is \$314 billion more than any other plan on the table, that managed competition according to CBO, pure managed competition that was introduced yesterday was a loser to the tune of over \$200 billion. So there is a \$500 billion spread between what a single-payer system does with first dollar coverage and what you get with managed competition in the pure form introduced yesterday.

I want to ask a question about unpure form, because Mr. Archey, you suggested that we have never had market forces in operation. It seems to me what you are asking for now is government-enforced market forces. There has been nothing in medicine to date that prevented people from dealing with the cost escalation; whether it was doctors or insurance companies or companies, they have all been trying to use the market forces.

What you are asking for is the government to come in and enforce it in some way. I would like to know what your bottom line is on what you want the government to enforce, because it is unusual for business to be coming asking the government to enforce some regulations to make things work better. I would like to hear what your bottom line is, how much government you want in this?

Mr. ARCHY. We would like as little as possible to make the system work and particularly to benefit our smaller companies who currently don't have the benefits that perhaps some of our larger companies have. That is why we like the idea of requiring the establishment of health insurance purchasing cooperatives; because we think that is going to give the smaller companies banding together a great deal more leverage and give them some of the buying power that in fact they haven't had and the other companies had.

Second, we are talking also about some stuff that you may call a mandate or a requirement. We think the government can facilitate, as opposed to the stronger word, mandate. We endorse the whole notion of providing information on outcomes, the ability of a consumer to make a more informed decision, but not under duress while they are on the way to the emergency room, to have accurate information as to what costs and outcomes are in a particular region or State along the lines of the Pennsylvania Cost Containment Council and others. There are a lot of things that we think can go on. There is one area where I think the government will have to be involved because of the question of the subsidy for small business.

We think that if you are going to stop cost shifting you have to get everybody into it. Small business is going to have a much more difficult time than the big guys. There has to be a subsidy. If you want to call that something that is going to have to be enforced by the government, we are in favor of it.

Ms. O'KEEFE. If I could say for the record, one of our frustrations with CBO's approach to costing out these various proposals is the fact that they have refused to score the savings that can result from well managed care. It is just not on the radar screen for them. It doesn't get into their projections. They literally base the cost of comprehensive mental health coverage, for example, on the old fee-for-service system, which is not what we propose and is not how providers are delivering those services for our employees.

Chairman STARK. Unfortunately, we are stuck with CBO figures. I agree with you, but that is ours not to reason why.

Mr. McCrery.

Mr. MCCREY. Mr. Archey, a quick question on your treatment of health benefits over and above some average. You said that you would consider that taxable income to the employee. Is that for all

employees of all employers, including large employers that would not be in the cooperatives?

Mr. ARCHEY. That would be for all employees.

Mr. MCCRERY. Thank you.

Chairman STARK. It is the Chair's intention to recess until noon and proceed again. There is a vote on. But I want to ask Dr. O'Keefe, you represent a large number of the Fortune 500 companies that would presumably be in this over 5,000 category. Could you make a guess as to what percentage of those companies with over 5,000 employees would opt to have their own health alliance?

Ms. O'KEEFE. As the President's program is currently structured—this isn't a firm answer, it is not based on a survey—but we have been asking around and as things stand now, very few companies would take them up on forming their own corporate alliances.

Chairman STARK. That is the Chair's opinion too, that most would find it better to go into the local alliance rather than do it on their own. Thank you.

One final question. You have dealt with the issue of cost shifting which you both suggest that you are worried about, as is the Chair. I am going to suggest just to see where you would come down on this that as a practical matter, as we begin to go through this there are going to be three choices, and I will preface this by saying that government spending covers about half of all medical spending in the country. If it picks up the uninsured it would be at about half. So the three alternatives that seem apparent at this point would be on the government side.

In each one of the three alternatives it appears that we could continue along in the Medicare style structure, negotiating for rates with doctors and hospitals and in effect setting the providers' or maximum prices. The question, then, is of the three choices it would seem to me, one, to have basically no controls at least defined on the private side. Probably that is where managed competition is; having a Medicare-like fee, although it would be higher than Medicare set for the private side for physicians and pharmaceuticals and hospitals; or the third alternative is the administration's, some kind of premium cap or gross expenditure controls for the private side but not for the public side. If those were your only three choices, and again there may be more, which one of those three would each of you prefer?

Ms. O'KEEFE. But given that choice, I guess I would pick A.

Chairman STARK. Which is to leave the private side with no cost controls or the present system which has been competition, no mandated cost controls for the private side?

Ms. O'KEEFE. On the purchasers you mean?

Chairman STARK. Yes. Or on the providers either. There is no enforced cost controls by—Mr. Archey.

Mr. ARCHEY. I would go A if I could amend A. Can we put in HIPCs as part of A?

Chairman STARK. Yes. I don't see they have cost control in them, but if you think they do—

Mr. ARCHEY. There are other possibilities. I would like to get back to you with D, E and F.

Chairman STARK. As I mentioned, either there would be a governmental cost on the top or the bottom; you either set prices and that ends up in a budget or amount and that ends up in prices or you depend upon a mechanism which has no risks and rewards or no controls. It may have risks and rewards anticipated, but nothing—you can say there is a fall back. That may be longer than people want to wait.

My own guess is we will finish that if we didn't put some cost control on the private side and then are asked to cut on Medicare and Medicaid, as we are, you would be back quickly asking us to control costs which experience shows will be shifted to you. My guess is you might be back asking us to change the structure.

Mr. THOMAS. Mr. Chairman, the three choices are pretty obvious in the way it is structured. It appears to me that your first choice is like the unintended acceleration problem in automobiles where you say no controls, it is on the private side, but somehow those cars moved without the operator doing anything. I think implicit in this first one is that all those changes governing the individual's choices in that structure will be changed in terms of providing more information and that there are governors or controls, and it is the same problem as with unintended acceleration—it wasn't the structure or the vehicle, it was the person in charge and that is the problem in the system now. It is the uninformed consumer.

Chairman STARK. Even with the tax cap there is nothing we suspect that that might change consumer behavior, but there is no law against it. In other words, they could still spend more if they chose, as opposed to an absolute law that says that is all you can spend.

We thank this panel. We will return in about 10 minutes.

[Recess.]

Chairman STARK. We would like to continue, and will convene our next panel.

I would like to welcome Larry English, who is president of the CIGNA Healthcare, which represents an alliance for managed competition. He is the man with the oxygen mask. Mary Nell Lehnhard, a senior vice president of the Blue Cross and Blue Shield Association; Karen Ignagni, the president and chief executive officer of the Group Health Association of America, and to recognize my distinguished colleague from Indiana, Hon. Jill Long, who has long been concerned not only about health care in general, but the issue of women's health care and women's rights, and I would like to recognize Jill at this point to introduce the fourth member of our panel. Welcome, Jill.

Ms. LONG. Thank you, Mr. Chairman and thanks for giving me the privilege of introducing the fourth member of this panel. Mr. Ian Rolland is the chairman and CEO of Lincoln National Life Insurance and Lincoln National Corp. He has a long history of working in health care and health insurance. He is the past president of the American Council of Life Insurance, the past president of the Society of Actuaries, past he is chairman of the board of directors of the International Insurance Society.

He is currently on the board of directors for Life and Health Insurance Medical Research Funds. He is the past chairman of the Health Insurance Association of America and in addition to all of the work that he has done professionally, I think it should be noted

that he is a person who cares about the clients that are served in the health insurance industry. In both his personal life and in his professional capacity heading Lincoln he has made a strong commitment to the community that I represent and also a strong commitment to the people of this country. So he comes to you testifying this morning not just as somebody who has expertise in health insurance, but somebody who really cares about people, and that is a very important component of this health care debate.

Chairman STARK. The only problem is it took him a lot longer than it took me to understand that one and two were the only answers to that theorem. I have known that for years because I wasn't going to try anything else. He has spent all his career trying to figure it out. That is an inside joke among us experts in mathematics.

We will ask the witnesses to proceed in the order that you were recognized and we will lead off with Mr. English.

STATEMENT OF LAWRENCE P. ENGLISH, PRESIDENT, CIGNA HEALTHCARE, BLOOMFIELD, CONN., ON BEHALF OF THE ALLIANCE FOR MANAGED COMPETITION

Mr. ENGLISH. Thank you, Mr. Chairman. I am Lawrence P. English, president of CIGNA Healthcare. Today in addition to representing CIGNA, I represent the Alliance for Managed Competition, which is an informal coalition of the Aetna, CIGNA, Met Life, Prudential and the Travelers. Together these companies provide health care and insurance for more than 60 million Americans.

I would like to emphasize at the outset the fact that the alliance companies strongly support the broad goals of health care reform as described by President Clinton. We are encouraged by the President's call for a bipartisan approach. We think that will be necessary to produce practical and beneficial changes in our system. Moreover, there are many specifics in the President's plan which we believe should be supported enthusiastically.

Among them are universal coverage, portability, the elimination of preexisting condition limitations, the elimination of cream skimming and cherry picking underwriting practices, the use of community rating, a standard benefit plan and malpractice reform. These concepts are not new to us. We have been advocating these and other reforms for some time.

We do have some concerns regarding the tools the President's plan would use to achieve its goals. Specifically, we are very concerned about the administration's plan's almost exclusive reliance on central planning and regulatory control rather than on the reform of the marketplace, reform in which consumers and providers could respond to positive incentives to make wiser choices about the efficient use of health care.

We are also very concerned about the proposed use of premium caps as a cost containment measure. Many knowledgeable individuals from almost every field of persuasion have spoken as to the ineffectiveness of price controls. They will stifle competition, they will drive away the private capital that is needed to continue to restructure the health care delivery system, a restructuring I would note that is already underway. They will also lead to rationing.

We are concerned about what the administration's plan has done to the concept of purchasing cooperatives or health alliances. These were originally conceived to be cooperatives in which individuals and small employers could freely select from a wide array of competing health plans. In the current proposal these cooperatives have emerged as giant regulatory bodies that would cover more than 99 percent of all businesses and more than 80 percent of all employees. The staff of these alliances could limit the number of health plans to be offered and they would dictate the prices those health plans could charge.

We strongly urge your consideration of the Managed Competition Act of 1993 introduced yesterday with the bipartisan cosponsorship of 27 Democrats and 17 Republicans, including Congressmen Andrews, Grandy and Congresswoman Johnson of this committee. We believe the Managed Competition Act holds great promise without the imposition of price controls, global budgets or regulatory health alliances. The market has begun the process of transforming the delivery of health care from the cottage industry it has been with lots of inefficiencies into a truly efficient system focus on quality and controlling costs.

Large and medium sized employers are already driving that transformation. They know full well that health care costs have impaired their competitiveness and they are getting their costs under control and maintaining quality by moving their employees into managed care plans at record rates. Increased competition for their business has placed an enormous demand on companies like ours to enhance the quality of what we do for both employers and employees.

Government might best proceed to encourage a more market-based system first by not scaring off the capital with the specter of price controls, by not creating unnecessary bureaucracy that will surely add to additional administrative cost, and by not limiting competition by having these huge, bureaucratically-laden alliances pick two or three favored plans.

Government should level the playingfield so that health plans can compete on quality and efficiency, not on risk selection, and should place incentives in place so that consumers and employers will fulfill the public interest through the pursuit of their own self-interest.

Third, the government should focus on the problem of those having the most problem with our current system, that is small employers and individuals. Everyone would benefit from the improved security that would result from comprehensive insurance reform, the creation of purchasing cooperatives designed to assist small employers and individuals gain access to the marketplace at competitive rates and that would make the promise of security a reality.

These reforms could transfer today's inefficient market for small employers and individuals into one that would be intensely competitive. We are convinced that these reforms could be achieved, that they would have broad support, that as a result the President and the Congress would achieve their goal for major reforms in the health care system, capital would continue to be available for the restructuring of the market, employers would be able to continue

their vitally effective progress in managing the health care cost and quality of health care of their employees, and most important of all the American people would enjoy greatly expanded access to quality care and the best medical system in the world delivered through a free, efficient and competitive market. Thank you very much.

[The prepared statement follows:]

TESTIMONY OF LAWRENCE P. ENGLISH CIGNA HEALTHCARE

Mr. Chairman, my name is Lawrence P. English, and I am president of CIGNA HealthCare. Today, I represent both CIGNA and the *Alliance for Managed Competition, which is an informal coalition of five companies that provide health care and insurance to more than 60 million Americans.

My company, CIGNA HealthCare, is one of the nation's largest providers of managed medical and dental care services and group life and health insurance. It operates a nationwide network of 77 health and dental maintenance organizations in the United States and 109 preferred provider organizations that serve nearly 5 million members across the country. CIGNA HealthCare also is one of the largest providers of managed mental health and substance abuse programs and a leading provider of employee disability management and medical cost control services. Currently, we provide insurance coverage to more than 14 million people.

At the outset of my testimony, I would like to emphasize the fact that the Alliance companies strongly support the broad goals of health reform described by President Clinton. We welcome the bipartisan cooperation that undoubtedly will be necessary to produce practical, beneficial changes.

With that position clearly noted, I would first like to comment on how the Alliance companies view the administration's plan. Second, I would like to put in perspective the type of fundamental questions the business community is asking about health care reform. Then I would like to offer some observations on the substantial changes that already are taking place throughout the industry and on practical efforts to initiate immediate additional reform.

First, some general thoughts about the administration's proposal. We are encouraged by the President's call for a bipartisan approach. Health care represents almost 15 percent of the U.S. economy. Reforming it will be an extraordinarily complex task that will require the intellect, diligence and good will of both political parties and of the numerous private sector "for-profit" and "non-profit" institutions that engage in health care delivery. No one has all of the answers, and it would be a tragedy to see the debate surrounding this important issue dominated by partisan or ideological arguments.

There are many specifics in the President's plan we believe should be supported enthusiastically. For example, such principles as:

- . universal coverage;
- . portability;
- . the elimination of pre-existing condition limitations and "cream skimming" and "cherry-picking" underwriting practices;
- . administrative efficiency through the elimination of paperwork and claim forms, a standard benefit plan;
- . community rating;
- . the implicit emphasis on network-based delivery systems;
- . the idea of purchasing cooperatives or, if you prefer, health alliances, to make markets more efficient;
- . malpractice reform; and
- . the objective, consistent measurement of quality and outcomes.

These concepts are not new to us. We have been advocating them for some time, and they form the essence of the administration's plan.

So, as I said, there is much that is encouraging. But, at the same time, we have some concerns, particularly regarding several of the tools this plan would use to achieve its goals. Our concern is that certain approaches will adversely affect our ability to achieve long term improvements while producing unintended consequences. This may be a once-in-a-lifetime opportunity for reform. Therefore, it's important to do the very best we can.

Specifically, we are concerned about the administration's almost exclusive reliance on central planning and regulatory control, rather than confidence in a reformed market place in which consumers and providers can respond to positive incentives to make wiser and more efficient health care choices.

If this proposal were to become law, we believe the new regulatory bureaucracies at both the state and federal level that would be created are excessive. New regulatory or oversight responsibility would be given to numerous existing federal agencies, while a new agency – a National Health Board, with very broad powers – also would be created. In addition, each of the 50 states would have at least one health alliance with powers to regulate all aspects of health care, which we believe would likely increase administrative costs. (without improving care for consumers.)

We also are concerned about the proposed use of premium caps as a cost containment measure. The proposal, as we know it, would impose rigid, centrally planned budgets that would result in sweeping price controls for a major sector of the U.S. economy. Our opinion is that such controls would have highly undesirable consequences on the delivery system of health services without delivering their goals.

From my own personal experience, I know that price controls don't work. Many knowledgeable individuals from virtually every field and persuasion have spoken to their ineffectiveness of price controls. I do not believe the government can stop clever people from evading them. Who will rule on the exceptions? Who will decide how to price a new treatment, a new technology, a new drug?

Further, it is my opinion that price controls will stifle competition. And they will drive away the private capital that is needed to continue the restructuring of the health care delivery system already underway.

Most important perhaps, it is impossible to conceive that national budgets can be met through the savings the administration envisions as a result of proposed Medicare and Medicaid cuts. Are there inefficiencies in the system? Yes, of course, there are, and they need to be eliminated. However, wringing them out will not provide sufficient funds to pay for all of the uninsured, expanded coverage for most, and add new benefits, such as pharmaceutical and long-term care for the elderly. The numbers simply aren't realistic, and they don't take into account other costly implications of the proposed changes. For example, the economic costs associated with increased coverage for retirees are immense and very difficult to forecast, as are the cost implications of the graying of America, which will generate increased use of the health care system.

Also difficult to quantify is the deterioration in quality, the delays and the outright unavailability of technology and medical procedures that are readily available today. In short, the arbitrary rationing that is sure to result from this kind of plan.

We also are very concerned with what the plan has done to the concept of purchasing cooperatives. Health Insurance Purchasing Cooperatives, HIPCs, or Alliances as they have become to be known, were originally conceived to be cooperatives in which individuals and small employers could freely select from a wide array of competing health plans at reasonable prices.

In the current proposal, these cooperatives have emerged as giant regulatory bodies – covering more than 99 percent of all businesses and more than 80 percent of employees – whose staff could limit the number of health plans to be offered and would dictate the prices they can charge. I am convinced that the size of these cooperatives will diminish competition, not increase it, and it will likely eliminate the incentive private employers currently have to continue to improve the health of their employees. They also are likely first steps in what eventually would become a single-payer, government-run system similar to that in Canada.

So, in summary, our view of the administration's plan is mixed. We unabashedly agree with its goals, but we have concerns about some of the means it would employ to achieve them. Resolution of these issues is not insurmountable. There are practical solutions which will not do harm to the 80-90% of our health care system that serves the vast majority of Americans well. We are committed to working with you to find those solutions.

Beyond our own perspective on reform, I've spoken with many of CIGNA HealthCare's clients and potential clients. I've heard many of the questions they have voiced about the administration's proposal. It is clear to me that, over the next several months, each company's management will be deciding which proposal works best for its respective business. The

conclusions undoubtedly will vary, depending on a firm's size, employee mix and number of retirees. But the questions all are certain to ask are the following:

- o Do we want the state or federal governments or both to establish the level of health care tax – disguised as mandated premiums – our company and our employees will pay in the future?
- o Do we want to have a direct role in determining the health benefits available to our employees and the cost of those benefits?
- o Do we want rules and benefits to vary from state to state?
- o Do we want to transfer the management of fifteen percent of the economy to the government?
- o And finally, what will the real cost of change be to our company going forward?

Answers to these questions are essential in judging whether the proposed changes will benefit or restrict economic growth in our country.

Now, let me offer some comments on the reform efforts already occurring within the health care industry.

Large and medium-sized employers already are driving reform. They know full well that escalating health care costs have impaired their competitiveness. They wield a very big economic stick, and they are using it to get their medical costs under control and maintain the quality of care. They are moving their employees into managed care plans at a record rate. As a result, more than 41 million Americans are now enrolled in HMOs and many more are in Preferred Provider Plans, Point of Service Plans as well as other plans involving some aspects of managed care.

The record shows that this spread of managed care techniques is rapidly reducing the rate of growth in health care expenditures. In other words, responding to consumer demand. It is changing the very infrastructure of the industry: doctors are joining networks or organizing themselves, hospitals are merging, new health plans are forming and new capital is being invested – all of which has increased competition exponentially.

Further, increased competition for this business places enormous pressure on us to enhance the quality of what we do for employers and their employees. Quality programs are proliferating. Every insurer I know of that wants to be a part of the health care system is focusing on system improvements that will strengthen service and lower administrative costs. They're moving ahead with "new world" technologies that use electronic data interchange and electronic funds transfer that will soon lead to a paperless health care system.

Even more exciting is the fact that competition is leading to innovations in medical care – innovations that improve treatment while lowering costs. For example, CIGNA HealthCare has developed more effective medical management procedures for pediatric asthma patients, improved existing biopsy procedures that aid in the diagnosis of breast cancer and initiated programs to identify and treat potential high-risk pregnancies.

All of these innovations improve the quality of treatment, from the patient's point of view, and at the same time, save millions of dollars. And, we are not alone in our innovations. Other managed care providers can cite similar innovations.

Moreover, not all of the improvement is coming from managed care providers. Employers, recognizing that lower health care cost is a competitive advantage, have initiated wellness programs aimed at keeping their employees healthy. Nutritional counseling, smoking cessation, fitness centers and well-baby programs are becoming common in the modern workplace.

The market has begun the process to transform the delivery of health care from the cottage industry it is now, with lots of inefficiencies, into a truly efficient system focused on quality and controlling costs.

Without being too presumptuous, I would like to suggest how the government might best proceed to encourage and move to a more market based system. From my perspective, government must level the playing field so that health plans compete on quality and efficiency not risk selection. We should put in place incentives so that consumer and employers will fulfill the public interest through the pursuit of their self interests. Government should not scare off capital – as it surely will – with the specter of price controls. Should not create unnecessary bureaucracy that will add to administrative costs. Should not limit competition by having huge

bureaucratically laden alliances pick two or three favored plans. Encourage competition. Let it flourish.

I, also, very much support and urge the government to play a part in enhancing competition and reforming those portions of the market that are not working well. I believe the federal government should create a Standard Benefits Plan, which would enhance competition and simplify administration. I think it should put in place an apolitical National Health Board to define the standard benefits plan, accredit accountable health plans (AHPs) and collect outcomes data.

Perhaps most important of all, I suggest that the government should focus on those having the most trouble with our current system. The problem, simply stated, is that small employers find all too frequently that group health insurance is difficult to get or too expensive to provide for their employees. Under current practices their premium rating can be distorted by a single claim, pre-existing condition limitations can make changing carriers difficult or impossible, and administrative and marketing costs can consume a disproportionate amount of their premium relative to large employers. Individuals face the same problem and, to make matters worse, they do not get the same tax preference employers get.

Everyone would benefit from the improved security that will result from comprehensive insurance reform. Surveys clearly show that, while the overwhelming majority is happy with its health care, people are frightened by the thought that they could lose their job or that their employer will cancel their plan, and that they will be unable to find affordable health insurance.

To correct these inefficiencies, I think the President and Congress would do well to focus on insurance reforms that eliminate pre-existing condition limitations, individual risk selection, and assure portability. I suggest they also should consider the creation of, or encourage the states to create, purchasing cooperatives designed to assist small employers and individuals gain access to the market at competitive rates.

These reforms would transform today's inefficient market into one that would be intensely competitive. All – not just a few – health plans would have to compete in the purchasing cooperative. The benefits would be standard. Employees and individuals would have free choice, and there would be no risk selection – competition would be based only on price and quality – and it would be fierce.

Competition, based on consumer choice, would decide who would offer service and who would not. These cooperatives would increase access, bring down cost and improve quality. The number of uninsureds would decrease. Americans would have the security of knowing that, if they lose their jobs or change jobs, they could find affordable health insurance – a virtual guarantee of portability. And, ultimately, the remaining uninsured could be given government vouchers or tax credits which would enable them to participate in the purchasing cooperative on an equal footing with other individuals. Eventually, Medicaid and even Medicare beneficiaries also could be brought into the cooperative, and universal coverage could be achieved without massive government intrusion.

I am convinced that these reforms could be achieved. They would have broad support, including ours. As a result, the President and Congress would achieve their goal for major reforms of the health system, capital would continue to be available for the restructuring of the market and employers would be able to continue the vital and effective progress they have already begun to make in managing health care costs and maintaining quality. But most important, the American people would enjoy greatly expanded access to quality care and the best medical system in the world, delivered through free, efficient and competitive markets.

Mr. Chairman, President Clinton and Mrs. Clinton have taken a brave step forward. Their goals are noble, and we heartily endorse and support them. Let us hope that in the spirit of building a bipartisan program, we can reconcile the many issues that undoubtedly will be raised in the coming discussions and bring about reform of the health care market place which will enhance competition, rationalize incentives, and promote wise decision making by providers and consumers alike. The American health care system will continue to have the best trained doctors, the most modern facilities and the best technology, equally available to all Americans.

Thank you very much.

Chairman STARK. Mary Nell, you are next.

**STATEMENT OF MARY NELL LEHNHARD, SENIOR VICE
PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION**

Ms. LEHNHARD. Mr. Chairman and members of the committee, I am Mary Nell Lehnhard, here representing the 69 independent Blue Cross and Blue Shield plans. Our plans applaud the President for moving health care reform to the top of his agenda and our plans support much of the proposal he has laid out. First and foremost, the Blue Cross and Blue Shield Association supports enactment of strict Federal standards for reforming the insurance industry. We agree with the President that insurance reform is one of the key elements—not the only element, but one of the key elements of comprehensive reform.

It is important for two reasons. First, insurance reform is needed to make sure consumers are treated fairly and that health insurance is responsive to the needs of consumers. Everyone needs to feel secure that every single health plan will, one, accept them no matter their health status or employment status; two, not drop people or groups because someone gets sick; three, be reasonable about preexisting waiting periods and eliminate them if we have universal coverage; four, use standards to establish rates that don't penalize people who are older or sicker; and, five, simplify paperwork if not eliminate it for both patients and providers.

The second reason we need insurance reform is that it is the underpinning for effective cost containment. We believe that the most effective way to control total health care costs is for the private sector to put its creative competitive energy into managing both the price of care and the use of services. You heard earlier from the employers about the success that primarily large employers are having in holding down increases by using networks of physicians who charge reasonable rates, but more importantly are committed to reducing unnecessary services.

We need to make sure that these kinds of delivery systems, these physicians and hospital networks, are available not just to large employers but to the entire market. Some insurance companies are doing this. However in the small group and individual markets most insurers have an overwhelming incentive to compete in that market based on selection of the best risks, to hold the premium down by including only the healthiest people and rejecting those who are sick rather than to truly manage costs.

Federal standards that require every insurer or health plan to accept everyone, rate them fairly and not drop them when they get sick would assure that competition even in the individual and small group market is based on cost management rather than risk selection. This isn't all we need to do to control costs. Consumers also need to be able to compare health plans for value and quality and that is very difficult to do now.

We agree with the President that insurers should be required to standardize benefits so consumers truly can compare health plans, provide data on quality again so consumers can shop, and provide information to consumers on enrollee satisfaction with the plan. Armed with this type of information, and again assurance that

every health plan will take you, all consumers can choose coverage for the first time based on value.

We, like the President, support a strategy for universal coverage based on employer and individual responsibility and we go into that more in our testimony.

We do have some concerns about the administration's proposal, primarily with respect to the large mandatory health alliances.

The primary reason for creating these alliances is to support the administration of individual choice. Every other function envisioned for the health alliance can be achieved through aggressive insurance reform and regulation of the insurance market as well as incentives to change the delivery system. For example, we support the dollar cap on the employer deduction for health expenses. While individual choice may be desirable long term, and we are not sure about the short term. Moving even the entire small group segment of the market group market into a mandatory alliance with individual choices would, we believe, result in complete confusion and disruption of the market.

In some States, for example, more than 70 percent of the population is in groups of under 100 enrollees. In all States, insurers would face, we believe, violent changes in enrollment to the point that they wouldn't know how to set a premium in advance of the open enrollment period. We have tremendous experience with this in the Federal employees health benefit program where, even in a very long-term stable program you have extreme difficulty knowing where to set your premium because you don't know who is going to be in your health plan.

We advocate instead voluntary purchasing cooperatives. Small employers could join these and, put their employees into a situation where they have individual choice. We believe we need to move gradually, gain experience and avoid a "fruit basket upset" situation, which is totally disruptive for the public. The bottom line is we shouldn't and don't need to make the success of reform dependent on establishing large, new bureaucracies that don't exist anywhere today. We can move now on insurance reform which will promote competition by keeping costs down and assuring quality, and allow us to move forward in our efforts to provide universal coverage using a genuine managed competition model.

Chairman STARK. Thank you.

[The prepared statement follows:]

TESTIMONY OF MARY NELL LEHNHARD BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. Chairman, and members of the committee, I am Mary Nell Lehnhard, Senior Vice President of the Blue Cross and Blue Shield Association. The Association is the coordinating organization for the 69 independent Blue Cross and Blue Shield Plans throughout the nation. Collectively, the Plans provide health benefits protection for about 68 million people. I appreciate the opportunity to testify on the important issues of reforming the private health insurance market.

Insurance Reform: The Foundation of Health Reform

There is a consensus across this nation and in Congress that insurance reform is one of the central elements in comprehensive health care reform. Fundamental changes in the basic rules within which insurers operate is a key component of the major health care reform proposals. As Congress begins the debate on health care reform legislation, I cannot overemphasize the significant impact of insurance reform on carrier practices. The types of insurance reforms that I will discuss would move the market away from competition based on risk selection. Risk selection is the reason we do not have true price competition in health care. It is easier for many insurers and HMOs to hold down costs by screening out high risks than by managing overall health care costs. A clear illustration of this point is that 4 percent of any population will generate about 50 percent of all the claims costs. If insurers have the choice, they will invest in techniques to avoid those high risks rather than invest in techniques to manage cost.

Insurance reform eliminates risk selection as a tool for maintaining competitive prices. Instead, insurers would have to compete on the basis of their ability to manage costs.

We believe that strict federal standards for the market conduct of insurers is the first and most important step toward reshaping the health care market -- and assuring fairness to consumers. Federal standards defining a health plan should:

1. Require insurers to accept everyone regardless of their health status or employment;
2. Strictly limit the length and use of waiting periods for pre-existing conditions and prohibit them entirely for people who have been continuously covered;
3. Prohibit insurers from dropping people or groups when someone gets sick, and require insurers to offer continued coverage when a person loses his or her job;
4. Require insurers to set premiums fairly and not penalize people who are sick or older; and,
5. Require insurers to comply with requirements for administrative simplification, including increased reliance on electronic data interchange and conformity to standards.

These same strict standards must apply to more than insurers and Health Maintenance Organizations. Self-funded plans must play by the same rules and be held to the same standards as Accountable Health Plans.

Insurance Reform By Itself Is Not Enough

While new rules for insurers are an essential part of health care reform, by themselves they will not be sufficient to contain costs and achieve universal coverage.

Cost controls: New standards for the way insurers do business can be an underpinning of a successful cost containment strategy. In addition, insurance reform will allow individuals, employers and employees to weigh both price and quality when purchasing coverage by requiring:

1. Standardization of health benefit designs. While we do not believe a single standardized benefit design will be workable, a limited number of standardized benefit designs will allow consumers to easily compare products.
2. Health plans to report standardized data on quality of care and subscriber satisfaction.
3. A limit on the tax deductibility of employer contributions for health benefits to an amount consistent with cost-efficient health plans.

These features will encourage the expansion of organized delivery systems that have a proven ability to change inefficient and ineffective utilization patterns and cause providers to become more efficient providers of health care.

Universal coverage: Making more affordable insurance available would reduce the number of people without insurance benefits, but it would not lead to universal coverage. A requirement for employers to offer and contribute to the cost of health benefits, and for individuals to accept and pay for the balance of the premium, would be necessary to achieve universal coverage.

Such a requirement, however, would impose a severe burden on many small employers. To make it possible for small employers to comply with the mandate, subsidies would be needed. These subsidies should be targeted to companies that rely heavily on low-wage workers.

Need to Increase Competition and Maintain Stability

Two elements of the Clinton Administration's recent proposal cause us concern. These include the proposal's reliance on large regulatory Health Alliances to perform an extraordinarily broad and complex range of functions, including compliance with the new standards of market conduct, and the proposal's reliance on global budgets and premium caps to control costs. We do not believe either large alliances or premium caps are necessary to achieve the goals of universal coverage and cost containment. Instead, we are concerned that both may lessen the effectiveness of the new rules governing the insurance market.

Large regulatory alliances: The Health Alliances would be called on to perform an extraordinary range of functions. Large regulatory Health Alliances would result in an immediate conversion of the vast majority of insurance from group coverage to individual coverage. While individual choice may be a long term goal for reform, dismantling the

system of group coverage poses grave risks for market stability. For example, fewer than 6,000 private business establishments have 1,000 or more employees. However, these establishments have more than 12 million employees -- more than 13 percent of total private sector employment. Abruptly requiring these millions of employees to individually select their health plan would have two destabilizing effects.

First, the administrative complexity of processing enrollment -- on an individual basis -- for 12 million individuals and families would add substantially to administrative costs. In addition, it would be almost impossible to avoid major confusion and disruption.

Second, as millions of individuals changed health plans -- both initially and annually -- the mix of risks -- and resulting costs -- insured by each health plan would change substantially and unpredictably. Such changes in enrollment are particularly likely because of several other elements of health reform, including standardization of benefits and community rating. Both provisions would change premiums significantly for many employers and individuals. Insurers cannot predict how consumers would react to such increases, making it very difficult for insurers to set premiums. They would literally have to set premiums in advance of knowing the characteristics of their enrollment.

The Administration has emphasized that a risk adjuster would address these problems of risk selection. We support risk adjustment, but do not believe that risk-adjustment methods would be sufficiently advanced to solve the problem. Our studies have consistently found that all health plans are not equally likely to cover higher-risk subscribers. In part, these differences reflect the extent to which some insurers can avoid enrolling people that are likely to need medical care. And in part, these differences reflect the preference of younger and healthier individuals and families for health care products such as Health Maintenance Organizations. Whatever the cause, it is not uncommon to find differences in risk of 20 percent or more across insurers and HMOs.

These differences in risk become important if community rating is adopted without a proven, reliable method of adjusting for differences in risk. Coverage from a plan that has suffered adverse selection could cost consumers considerably more -- for the same set of benefits -- than coverage from a health plan that has avoided high-risk subscribers. It has been established that many individuals and families will change health plans in response to differences in premiums of as little as \$20 per month. Those who are most likely to change carriers are younger and healthier subscribers.

Risk adjustment is still in its infancy. The impact of age and sex on costs has long been recognized. For example, a person age 55 will, on average, incur costs that are four times higher than a person age 25. However, these simple demographic adjustments account for only a small part of the difference in premiums that can be attributed to risk selection. For example, in a comparison of products that are virtually identical in terms of benefits and provider networks, demographic factors accounted for only a small fraction of the difference in costs.

When additional information is considered, including measures of self-reported health status and use of health services in prior years, we can account for more of the difference in costs. But, even our best methods account for less than half of the difference. States are currently experimenting with a number of solutions to the problem of risk adjustment, but none have yet proven themselves.

Unless an effective method of risk adjustment is developed, plans serving higher-risk groups and communities could be forced from the market. In practical terms, this means that we should proceed cautiously with reforms that may make it impossible for health plans with higher-risk subscribers to compete on a level playing field.

We recommend that options for individual choice be expanded gradually. Voluntary purchasing cooperatives could be formed to allow small employers to offer their employees choice of health plans on an individual basis.

With respect to rating reform, community rating with demographic adjustments should be enacted for small employers, with between 2 and 49 employees. Such a requirement would eliminate those rating practices that have made health coverage unaffordable for many small employers and have had the most destabilizing effect on the small group markets. Insurance premiums would no longer vary widely for a small employer with older employees or an employee with a serious health problem. And rate increases from year-to-year would become more predictable for small groups. It would also be possible to develop, test, and refine more effective methods of risk adjustment while maintaining stability in the larger group market.

Premium Caps and Global Budgets: Global or alliance budgets administered through premium caps promise less spending, but we believe they would prove to be ineffective and would preclude a smooth transition into a more competitive and efficient system.

1. Premium caps would be driven by federal budget priorities and politics that have little or nothing to do with health care. One decision in Washington would determine the amount of money available to provide needed health care in each Health Alliance area.
2. By relying on a process that is not a reliable predictor of how fast communities should be expected to eliminate inefficiencies, premium caps would force the rapid downsizing of provider networks, reduced availability of sophisticated diagnostic and treatment technology, increased waiting times for consumers, and a decline in customer service. Plans that cannot comply with the limits would either be forced from the market -- or forced into insolvency. The end result would be fewer choices for consumers.
3. Premium caps would limit the innovation needed to truly change behavior, by limiting the ability of health plans to invest in ways of better managing practice patterns and achieving better outcomes for their members.

4. In the absence of proven methods or risk adjustment, health plans could exceed their premium cap because they have enrolled higher-risk subscribers not because they do not effectively manage costs.

Although some argue that premium caps are needed to enforce limits on spending, we believe that the new rules for health insurers will lead to vigorous price competition that will be more effective in controlling costs over the long run and support a more orderly transition into a reformed health care system.

Conclusion

I would like to reiterate our strong belief that insurance reform is the key to containing costs and assuring access to coverage. Reforms are needed to make coverage available for employers that have an employee who has a serious medical condition, reduce the wide variation in premiums charged to groups based on their health status, limit increases in premiums for small employers that result when an employee develops a serious medical problem, and assure coverage for individuals with existing medical conditions.

Federal policies to give employers and individuals a greater incentive to select cost-efficient health plans that delivery high quality care, and to enable them to compare the options that are available in a reformed market will complement insurance market reform. The benefits of reform can be realized without resorting to either premium caps or large Health Alliances that could actually work against the objectives of reform.

STATEMENT OF KAREN IGNAGNI, PRESIDENT AND CHIEF EXECUTIVE OFFICER, GROUP HEALTH ASSOCIATION OF AMERICA, INC.

Ms. IGNAGNI. I am Karen Ignagni, I represent the Group Health Association of America. We have 347 plans that we represent consisting of 32 million members. We are delighted to participate in this hearing today and have submitted our text to you for review of our prepared remarks. If you will pardon my informality, as I was listening this morning, I would very much like to throw out my prepared oral statement and address some of the points that you and many of your colleagues made with respect to where we are going in the delivery system.

A number of you talked about the existing CBO report and the draft GAO report with respect to the performance of managed care systems. I would like to raise several points with you this morning about that report. The first is that I think speaking plainly we in the HMO industry have not done enough to tell our story about what has been going on, what major changes have been going on in the delivery system and how effective they are, not simply on the cost side, which is terribly important, it goes without saying in the debate, but I think more importantly for our long-term objective of society in terms of getting a handle on this problem, the quality side.

I am new to the HMO industry and in that regard have been looking at a great deal of data over the last several months and I have been very much struck by the track record that is out there. You raised the issue with respect to whether or not our plans are successful in treating younger versus older population and implied, many of you, that perhaps you were confused about what evidence exists with respect to the performance of managed care systems in populations that are not young and healthy.

Let me direct some comments directly to the Medicare risk population.

Chairman STARK. Before you bury me, let me say that my suspicion, is that where there is a choice it is in the fee-for-service program for those services that are the IPA model, which are not HMOs, not staff model. The workers who are bright select those plans. I wouldn't argue with you for a minute that HMOs, particularly the staff model, are the most efficient way to deliver medical care if all you are concerned with is cost. Absolutely none, and they provide pretty good quality.

It is where there is an option and people opt out, and the fee-for-service costs go up because the older, sicker people pick them so they can go to Mayos which they can't do in Kaiser. So the company's cost in the aggregate may not go down at all.

Ms. IGNAGNI. Let me direct myself directly to your hypothesis, Mr. Chairman. If you look at the Medicare risk contract program where a number of plans both in the group practice model HMO, as well as in individual practice model HMOs are participating, I would tell you that the data are very significant in terms of the track record as compared to what the HMOs are providing, what they have seen in terms of cost per case, length of stay.

There have been increases on the right side of the equation, on increased usage of home health prevention, and decreased utiliza-

tion in terms of inpatient care, nursing home care. Exactly what I think most of you would like to have in the system, to put more emphasis on the front end. We have not, I think, done enough to really communicate that experience and we are going to set out to do that.

I wanted to raise that issue with you and also tell you that we will be actively working with CBO, OMB and others to try to provide experience and assistance on the issues that we know best and where we can tell a story that I think has not yet been told.

Point two is, our experience is in the area of the delivery system. I would like to direct my attention with respect to the President's proposal, although you have examined a number of elements with respect to that proposal this morning, to the delivery system and make several points.

The first is from the standpoint of plans trying to navigate and operate within a confusing maze of regulations. We believe it is absolutely imperative that the Federal Government set out to define the rules of the game, that we level the playingfield and there is no inherent advantage to consumers in the end living in one State or another. Let me tell you what I mean by that.

We have a series of patchwork regulatory imperatives out there now that plans have to comply with. It is confusing to consumers and plans and I submit it is not the experience on which we want to build a national reform. So at the Group Health Association of America we are in the process of developing a proposal that we hope to be helpful and share with you as a way of beginning the debate with respect to the standards and what the delivery system should look like.

The second point I would make is in the area of the purchasing alliances and the reach of the purchasing alliances relative to what plans are doing now. Our plans have engaged in some path breaking work with respect to report cards, with respect to developing data that all of my colleagues have referred to. I think we want to encourage plans to continue down that road as opposed to discouraging and preempting that.

I think as you navigate your way through the maze of hyperbole and confusion with respect to the choices before you, we would ask that you look very carefully at what has been done out there, what is in the process of being done and how it benefits the consumers and how we can continue that rather than stepping back and taking another turn.

Speaking on behalf of our association we hope to be as helpful as we can to provide you the information necessary to understand what is going on out there and hopefully the directions that you can and should proceed. Thank you.

Chairman STARK. Thank you.

[The prepared statement follows:]

**TESTIMONY OF KAREN IGNAGNI
GROUP HEALTH ASSOCIATION OF AMERICA, INC.**

Mr. Chairman and members of the Subcommittee, I am Karen Ignagni, President and CEO of Group Health Association of America, Inc. (GHAA). GHAA is the oldest and largest national trade association of health maintenance organizations (HMOs). Our 347 member companies serve 32 million enrollees, approximately 75% of the total national HMO enrollment.

We are pleased to have this opportunity to share our views on the President's health care reform plan. We applaud President Clinton for his leadership in moving health care reform to center stage and placing universal coverage at the forefront of the American agenda. We share the President's goals of assuring access for all Americans to comprehensive benefits, giving our citizens piece of mind by prohibiting waiting periods for coverage and doing away with pre-existing condition exclusions; establishing the principle that all plans should be accountable for quality of care and the quality of service that they provide; and protecting the right of all consumers to choose the plan that best meets the needs of their families.

The proposal's emphasis on managed care is both exciting and challenging for the HMO industry. It is our conviction that expansion of well-structured, fiscally sound managed care options can play a major role in achieving comprehensive, high quality health care at an affordable cost for all Americans. As Congressional consideration of health care reform proceeds, we realize that the question "does managed care generate enough savings to deserve a central place in the debate" will be prominent. We believe that the answer is yes, but we also believe that this question deserves another look. It may be diversionary, and indeed counterproductive, to let the health care policy debate become unduly fixated on questions of money alone. Certainly we should pay at least as much attention to quality - and to the role that managed care can play in bringing high-quality and affordable health care to the millions of Americans who are uninsured, underinsured, or underserved.

HMOs have a dramatic success story, providing high-quality health care at predictable cost to consumers who, in survey after survey, give HMOs positive reviews. Yet the HMO model, once derided as "socialized medicine," is still misunderstood, perhaps in part because it is so often described simply as "managed care" - an accurate term but easily misconstrued. Many fee-for-service plans try to manage care. HMOs offer coordinated care.

Every HMO member chooses a primary care physician who acts, in effect, just as family doctors used to do - learning the needs of patients and their family members, keeping track of defined patient populations, promoting preventive care and sound health maintenance practices, and making referrals to specialists when necessary.

Coordination assures patients of high-quality care while also making it possible for HMOs to manage costs far more efficiently and effectively than is possible under uncoordinated fee-for-service care. Coordinated care also gives HMO health care professionals a wealth of information with which to monitor quality. Ongoing internal quality reviews are, in fact, a hallmark of the HMO health care model.

The need for national health care reform has been well documented. Now Americans are debating how to provide guaranteed health security for all of us at a cost that all of us — employers and employees alike — can afford. HMOs offer a proven model for reform.

- **UNIVERSAL COVERAGE** at broadly affordable cost becomes possible only when insurance risks are spread across a large community. Currently, most health coverage is priced using "experience rating," where high premiums are set for high cost groups and low premiums are set for low cost groups. Experience rating financially discriminates against populations that experience high costs: the very young, the very old, the chronically ill, and those with pre-existing conditions, such as diabetes. Nearly all HMOs employ community-rating, basing their premiums on the average cost of serving entire subscriber communities. Rather than controlling costs by excluding the sick, HMOs work at keeping their communities healthy. Rather than manage the risk, HMOs manage the care.

- **COMPREHENSIVE BENEFITS** are meaningful only if access to those benefits is assured. HMOs offer comprehensive benefits (in most cases at least equivalent to those being proposed under the principal reform proposals), and assure access to those benefits by (1) keeping out-of-pocket costs low — generally eliminating deductibles and requiring only minimal-copayments for some services; (2) maintaining relationships with the right number and mix of providers to meet their members' needs; (3) coordinating care; and (4) maintaining effective quality improvement programs.

- **QUALITY OF CARE** can be systematically enhanced only under a system that provides care to an enrolled population. The HMO model, centered as it is on the role of the primary care physician, has built-in safeguards to assure that appropriate care is provided and unnecessary care is avoided. This is the basic principle that allows HMOs to offer cost-effective quality care. HMOs develop practice guidelines based on direct experience and research. They recognize, too, that uncontrollable cost increases can be avoided not just by delivering care more efficiently but by constantly improving the quality of that care. With access to detailed information on services provided, HMOs can analyze the care and can implement appropriate guidelines to improve outcomes. HMOs constantly reinforce this approach, and can provide a blueprint for quality-of-care standards across the country.

- **ADMINISTRATIVE COSTS** can be brought under control when administrators and care providers are working together. By integrating financing and delivery of health of care, HMOs eliminate needless and costly paperwork. Far from rewarding inefficiency, HMOs stake their future on being able to control it.

- **COMPETITION** under a reformed health care system can play a key role in bringing the nation's total health care bill under control. If competition is based on price alone, however, the savings will be illusory. HMOs, with their emphasis on coordinated care and comprehensive benefits, are structured to facilitate competing on quality and cost-effectiveness. The rapid growth of HMOs testifies to their competitiveness. At the same time, however, they have had to compete on a less-than-level playing field, hampered by anti-managed-care state laws and by competitors' pricing practices. For example, some traditional insurers have tried to keep their premiums under control by erecting barriers to care — sometimes hidden (for example, waiting periods for coverage); usually painful (increased deductibles and other cost-sharing requirements); and often arbitrary (exclusions

for pre-existing conditions). *True competition requires being able to offer comprehensive benefits with no strings attached* — which is a good working definition of the HMO model.

- **FREEDOM OF CHOICE** can be enhanced under a reformed health care system first by guaranteeing universal coverage — since people without insurance can make few if any real choices about their health care — and by making sure that consumers have access to competing plans, including both fee-for-service and managed-care models. Consumers can make more informed choices by being provided standardized information about the quality and cost-effectiveness of competing plans, by being given the opportunity to change physicians within a plan, and by having the freedom to change plans periodically. HMOs already offer members these and other kinds of choices, including, under some benefit options, the opportunity to choose specialists not affiliated with the HMO. And national health care policies that increase the supply of primary care physicians will, of course, give consumers still more choice in selecting among competing plans.

- **COST CONTAINMENT** nationwide on a sustained basis becomes feasible in a system that encourages competition and reinforces marketplace incentives in health care. Proposals that rely heavily on regulation to control costs are likely to be counterproductive, in that they could unintentionally penalize HMOs that have been able to keep premium rate increases lower than fee-for-service plans, and could limit health plans' ability to raise the capital necessary for growth. The better approach to cost containment is to manage costs as HMOs do, by encouraging enrollees to select a personal physician to coordinate their care, emphasizing the effectiveness of care, and incorporating cost-consciousness in every decision.

One issue that must not be overlooked is the importance of planning for the anticipated growth in enrollment in HMOs and other managed care organizations which the Clinton plan and other reform proposals anticipate. We hope that this area will be fully explored as the Congress moves forward on health care reform. This is the best "problem" our industry could face, but it also one which needs to be addressed early on by policymakers. The increase in the supply of primary care physicians which is contemplated in the Clinton plan and in legislation introduced in both the House and Senate will be crucial to the expansion of managed care plans. In addition, there will be an increased need for experienced health plan managers. Capital generation which is sufficient to support growth will also be essential, and capital needs must be considered when any cost containment mechanism is under discussion.

In addition to these general comments, we have several specific areas within the President's proposal that we would like to highlight.

Uniform national standards for health plans

The Clinton plan's establishment of federal Conditions of Participation to define a set of uniform national criteria for participating health plans is a positive step. However, we believe that these federal standards should be broad enough in scope that additional state and alliance criteria should be unnecessary. A system with wide variations in regulation from state to state will be needlessly confusing and frustrating, and it could mean varying levels of consumer protection. GHAA is in the process of developing a proposed set of criteria which would apply to all managed care plans

and will address the need for basic standards for fee-for-options as well.

In our view, federal standards should address areas such as accessibility of services, adequacy of quality improvement systems, and evidence of fiscal soundness. Any additional requirements for state guarantee funds should be unnecessary if these criteria are met, but in any event must operate to make successful health plans pay the price for insolvencies resulting the mistakes of regulators and the shortcomings of less competent health plan management.

If HMOs and other managed care plans are to flourish, restrictive state laws, such as those requiring that "any willing provider" be permitted to affiliate with any health plan, should be preempted. The ability of HMOs to selectively contract with providers who are well-qualified and who are needed to maintain the appropriate mix of practitioners to best serve enrolled members is fundamental to their success.

Regional alliances

We are awaiting the Administration's proposed legislation to better understand the functioning and structure of the alliances within the health care reform plan. While there appears to be some consensus that pooled purchasing arrangements can successfully address the problems of the small group market, many questions remain about operation and value of the very large alliances outlined in the Administration's plan. It may be worthwhile to consider implementing purchasing pools for the small group market in the near term, and with this experience as a foundation, assessing the impact of alliances which would encompass 90% or more of the health care marketplace.

If alliances are created for the small group market, we agree that all qualified health plans should be permitted to participate in them. This will afford equitable market access for health plans and will promote a wide range of choices for consumers.

Cost Containment

The President proposes to encourage cost containment by creating a nationwide network of health care purchasing alliances to negotiate with HMOs and other managed-care plans, as well as with fee-for-service providers. But the President plans to "backstop" that approach with controls on premium increases, which could undermine efforts by managed care plans to bring cost-effective care to more Americans. The President's cost-containment goals are commendable. HMOs, however, have long demonstrated their commitment to providing quality care at affordable cost - by coordinating the care of a defined population while maintaining the flexibility to respond to special needs. Since the Administration seeks a nationwide system along the same lines, it makes sense to encourage HMOs and other managed care delivery systems that meet uniform standards to do what they do best, unfettered, rather than threaten them - at the outset - with price controls.

Benefits

The proposed comprehensive benefit package, which emphasizes preventive care, builds upon the successful experience of HMOs, and we believe establishment of such a national standard is a fundamental building block of successful health care reform.

Quality Monitoring and Data Collection and Analysis

The present commitment by private sector employers and HMOs to the refinement and expansion of the performance measures contained in HEDIS, as well as to the goal of standardized data collection and reporting, is rapidly moving the managed care industry toward better and more useful information for consumers. It is encouraging that this first step toward fulfilling the objectives of the Administration's proposal is already underway. In light of this activity, however, the creation of a massive data network and a sizable regulatory structure to analyze the data and prepare reports for consumers has the potential to inhibit progress thorough the inability to readily incorporate improvements as they are developed. We urge that any health care reform measure should build upon efforts already in progress and allow sufficient flexibility to take advantage of advances as they become available.

We have appreciated the opportunity to share our views and look forward to working with you as your consideration of health care reform continues.

Chairman STARK. Mr. Rolland.

STATEMENT OF IAN M. ROLLAND, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, LINCOLN NATIONAL LIFE INSURANCE CO., FORT WAYNE, IND., ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. ROLLAND. Thank you, Mr. Chairman. I am Ian Rolland, chairman and CEO of the Lincoln National Life Insurance Co. Our affiliate employers health insurance is a primary supplier of health insurance to small employers. It also administers and markets the new California purchasing cooperative.

I am here today on behalf of the Health Insurance Association of America, the industry trade group representing 270 commercial insurance companies providing coverage to 65 million Americans. My remarks today reflect our understanding of what the President will include in the legislation expected on the Hill soon.

Comprehensive health care reform is the Nation's highest domestic priority now, as we believe it should be. There are 37 million Americans without health insurance coverage and many others are without the coverage they need particularly with regard to preventive services or they fear they will lose it if they change jobs.

Health care costs continue to spiral upward. The system needs to be reformed, as the President said in his speech to the Congress on September 22. It is time to fix it. We, the Nation's commercial health insurers, agree. The President correctly identified the six principles on which we believe true reform must be built—security, simplicity, savings, choice, quality and responsibility.

We agree with the President and the many Members of Congress and this subcommittee who have developed reform proposals founded on these principles. HIAA's own vision for health care reform is predicated on them. So let me tell you just what we stand for and why I think we share much in common.

We are for cradle-to-grave coverage for all Americans, no exclusions for existing or previous illness, coverage cannot be cancelled if you get sick. If you change or lose your job, coverage goes with you. Employers and employees both pay toward coverage. Subsidies for those who cannot afford premiums, control malpractice law suits and unnecessary tests, publish price and quality data, single claim forms to control paperwork, incentives for healthy lifestyles, stop shifting costs of Medicare and Medicaid to those with private insurance, and the use of managed care to control costs.

Mr. Chairman, the HIAA has three major objections to the President's plan based on our reading of the September 7 working group draft. We oppose monopolies granted to health care alliances, limits on premium increases and global budgets and the use of pure or flat community rating.

First, the mandatory health alliances. Aggregating purchasing power is the intended objective of the health alliances. We certainly do not oppose the theory, but we do oppose giving these alliances the power to preselect which health plans will be offered and just as important requiring that employer groups below 5,000 must purchase their coverage through the alliance.

HIAA would favor having the government establish purchasing alliances or cooperatives on a voluntary base. Under this system,

employers and individuals would not be forced to purchase their coverage through the alliance. They would have the option of purchasing through the alliance or maintaining their current coverage. All health plans, whether or not they purchase or participate in the health alliance, would have to play by the same rules. So neither the alliance nor the plans operating outside the alliance would receive an inequitable share of risk.

Insurance reform such as elimination of preexisting condition limitations and guaranteed issue of insurance along with a risk adjustment mechanism would be applied to plans offered both inside and outside the alliance.

As I said before, we have some experience with the voluntary California purchasing plan. Our early experience in that plan demonstrates how competition can work. As of October 1, 3 months after the plan has been opened, 17,484 individuals are enrolled in 1,068 groups. Twenty percent of those groups were previously uninsured. To the best of the knowledge we can obtain based on early data, the cooperative is getting a reasonable spread of risk.

Premium caps and price controls. In effect the administration's proposal would, after a transition period, force insurers to constrain national health care spending at a rate no faster than the increase in the CPI adjusted for population growth. To achieve this a plan would cap premiums charged to a weighted average premium.

Starting down that road of price controls and premium caps would be an enormous mistake. The United States experimented unsuccessfully with price controls in the 1970s and as a result the CBO points out "effective limits on premium increases would affect both the quality and quantity of health insurance coverage available to consumers and their future access to new medical technology."

We in our industry are extremely concerned about the impact of premium caps on the quality of care. They could lead to treatment decisions based solely on cost rather than quality. They also would force insurers to interfere unnecessarily, we believe, in the doctor-patient relationship.

Mr. Chairman, we support reform. We are willing to change the way we do business so that no American loses their choice of insurance coverage. What we are asking for is the ability to compete, nothing more, nothing less. We want to work with your subcommittee as you proceed to develop a sound health care policy for America. Thank you.

[The prepared statement follows:]

TESTIMONY OF IAN M. ROLLAND HEALTH INSURANCE ASSOCIATION OF AMERICA

Good morning, Mr. Chairman and Members of the Committee. My name is Ian Rolland and I am the Chairman and Chief Executive Officer of the Lincoln National Life Insurance Company. I am here today on behalf of the Health Insurance Association of America which represents approximately 270 commercial insurers covering approximately 65 million Americans.

Mr. Chairman, we commend the President for coming forward with an ambitious blueprint for reform of the nation's health care delivery and financing system. With approximately 37 million Americans currently without health insurance coverage, and health care costs consuming an ever greater share of the Gross Domestic Product, there can be no question regarding the imperative for comprehensive reform.

In his speech to a Joint Session of Congress on September 22, President Clinton identified six fundamental principles on which any reform plan must be based: security, simplicity, quality, savings, choice, and responsibility. These are the same principles on which HIAA's own Vision for Reform was constructed last year. I would like to submit a copy of our Vision Statement for the record.

In communications with the Administration, Members of Congress, and the general public, HIAA has repeatedly stressed its wholehearted support for these principles, and has proposed specific means by which they can be implemented. Let me emphasize what we're for:

- "Cradle to grave" coverage for all Americans.
- No exclusions for existing or previous illness.
- Coverage cannot be canceled if you get sick.
- If you change jobs or lose your job, coverage goes with you.
- Employers and employees both pay toward coverage.
- Subsidies for those who cannot afford premiums.
- Control malpractice lawsuits and unnecessary tests.
- Publish price and quality data.
- Single claim form to control paperwork.
- Incentives for healthy lifestyles. Emphasis on wellness and prevention.
- Stop shifting costs of Medicaid and Medicare to those with private insurance.
- Using managed care to control costs.

While we have only reviewed the September 7, 1993 "Working Group Draft" and not actual legislative language, there are elements on which we and the Administration

would seem to agree. There are, however, three particular points of disagreement with the President's plan:

- reliance on exclusive health alliances;
- the use of premium caps and other price controls.
- the use of flat community rating.

HEALTH ALLIANCES

The President's plan calls for the creation of large, government-mandated purchasing pools through which everyone, except persons employed by an employer with more than 5,000 employees, must purchase insurance. The theory underlying this concept is that a large pool of purchasers will have significant market clout to bargain for low-cost health care – market clout which small employers lack today. These mandatory government alliances will be responsible for selecting which health plans will be offered and will have the power to limit the number of plans offered even if there is consumer interest in purchasing an excluded plan. This does not seem consistent with the goal of consumer choice or the goal of competition. And this approach removes the employer from the equation except as a contributor toward the insurance costs of employees and their dependents. This lessens substantially the employers incentive to offer wellness programs to lower health benefit costs. And the employer loses the "bargaining power" promised by the alliance because the alliance, not the employer, selects the limited number of plans to be offered.

All individuals and employers with less than 5,000 employees will be denied a key choice in the new system – they may not be allowed to retain their current insurance coverage or plan. Not all plans will be allowed to compete in the new system. What happens to those consumers who want to retain their current plan? Or purchase their coverage from an agent, who is, in essence, a benefits advisor to the employer? Below are a number of ways that the Administration's plan will actually deny choice for millions, according to their September 7, 1993 "Working Group Draft."

- In a state which elects to establish a single-payer health care system, there will be no choices of health plan at all (page 54).
- If a plan's premium exceeds the average by 20%, it need not be offered by the health alliance even if some families want to buy it (page 60).
- An alliance may exclude a plan if the proposed premium would cause the alliance to exceed its budget target even if some families want to buy it and even if the premium difference is insignificant in amount (page 61).
- An alliance may offer no fee-for-service plan if in its judgment the plan is not viable (page 62). (How can they know it's not viable if they don't

offer the plan to find out if there is sufficient interest in it? What standard is used for viability?)

- An alliance may offer only one fee-for-service plan (page 62). (There are differences in fee-for-service plans even if every physician and hospital in the community is included. These include differences in promptness of paying bills, and differences in levels of customer satisfaction.)

Proponents of these alliances also suggest that significant administrative savings can be realized. HIAA believes such savings have been overestimated. Certain administrative functions must be performed by the alliance. These include plan enrollment, premium collection, claims payments, and fraud detection. Under the President's plan, enrollment is handled through the alliance. Today, employers handle employee and dependent enrollment. That cost is not reflected in their insurance premiums. Most employers send premium payments directly to the insurer or health plan. Under the President's plan, the alliance will handle the enrollment of individuals, collect the employer and employee share of the premium, and forward premium payments to the plan selected by the employee. This can result in significant administrative expense for the alliance when one considers that everyone except employees of the very largest employers in the region must purchase coverage through the alliance.

Health alliances are untested. The states that have authorized purchasing alliances in place have made them voluntary; only one is currently operational. The Administration's plan forces anyone who works for a company with less than 5,000 employees, and all people with individual health insurance coverage into the new alliance structure. In essence, that means that 80% of all Americans, roughly 200 million people [these numbers include everyone except 30 million Medicare recipients and 20 million workers and dependents whose employers would be eligible to establish Corporate Alliances. Source: "Congressional Health Care Workshops" materials dated September, 1993], will be receiving health coverage through an untested alliance system. There is no precedent for such massive change to a process so essential to the welfare of all Americans. After all, according to a June 1993 "Harvard School of Public Health" survey, 77% of Americans surveyed are pleased with their health care coverage.

The health alliance structure effectively bars entry of new plans after the initial years. Plans not selected in the first year will be unable to compete in the region, and will not be around to bid the following year. Within a few years, only a handful of competitors will remain in each alliance area. The plans that survive may not be the most efficient and effective. Success in the early years of the alliance may depend more on a plan's ability to "sell" itself to individual consumers through media advertising, than on the quality or efficiency of the care it delivers. The plan creates a disincentive for competition that would lead to market constriction. If consumers do not like the plans offered by the alliance and are on the receiving end of poor customer service (for example, they can't get their calls to the 800 number answered) they do not have any alternative – it is the "only game in town."

One alternative to monopoly health alliances are voluntary health alliances. HIAA would favor having the government establish purchasing cooperatives or alliances on a voluntary basis. Under this system, employers and individuals would not be forced to purchase their coverage through the alliance, they would have the option of purchasing through the alliance or maintaining their current coverage. All health plans, whether

or not they participate in the health alliance, would have to play by the same rules so that neither the alliance nor plans operating outside the alliance would receive an inequitable share of risk. Insurance reforms, such as the elimination of pre-existing condition limitations, and guarantee issue of insurance, along with a risk adjustment mechanism, would be applied to plans offered both inside and outside the alliance.

If health alliances are truly more administratively efficient, and better at pooling risks, then the carriers operating through the alliance will have lower premiums and will naturally gain market share. If, on the other hand, employers and individuals prefer to deal directly with an insurance company rather than a large bureaucracy, they would have that choice. The market, not the government, should determine which is the more efficient way to insure all Americans.

The State of California has set up a voluntary purchasing plan called the "Health Insurance Plan of California." This plan is administered and marketed by Employers Health Insurance Company, a subsidiary of Lincoln National. The plan was up and running on July 1, 1993, and has grown substantially. In just three months the plan has covered a total of 14,500 enrollees, 13,000 of which are under the age of 50. Eighteen plans are offered for participants to choose from, 15 HMOs and 3 PPOs. A total of 900 employer groups, varying in size, from 5 and 50 employees each, participate. The State of California is split into 9 geographic regions. Today, two-thirds of the new groups are sold by agents. The plan receives over 2,000 calls per day for information. Other states are in various stages of setting up voluntary purchasing alliances - Florida, Washington and Minnesota, to name a few. All alliances that have been developed in the states have voluntary, not mandatory participation.

PREMIUM CAPS AND PRICE CONTROLS

The U.S. experimented unsuccessfully with price controls in the early 1970's; we should not repeat the mistakes of the past. Price controls would entail extensive government rationing because in order to control costs you must control volume as well as prices. The Administration's proposal, after a transition period, would constrain national health care spending to increase no faster than the rate of increase in the Consumer Price Index, plus population growth. To achieve this, the plan would cap premiums charged to a weighted average premium. Limiting health insurance premiums doesn't affect rising provider charges, the increasing volume and sophistication of services provided, or continuing medical progress. In a study released last month, the Congressional Budget Office questioned the efficacy of premium controls, commenting that they would have undesirable consequences. "Effective limits on premium increases would affect both the quantity and quality of health insurance coverage available to consumers and their future access to new medical technologies."

Implementing the President's plan will require significant new capital investment, but there will be no incentive for private investment. In a price controlled/premium capped market, companies will be severely impaired in their efforts to attract capital. Capital will be needed to organize the networks of hospitals, doctors, and other providers that are the core of the new system. Capital is needed to assure that health plans have adequate reserves to cover unexpected losses and guarantee solvency. The new system will require more capital than the current system both to cover the 37 million uninsured and to cover the many millions of employees who will have to shift from self-insured employer plans to fully insured plans offered through the health alliance system. Most self-insured plans are not likely to have any significant reserves to offset the capital requirements. These capital requirements raise great concern about the solvency of health insurers. Over the last decade, the profit margin of the health insurance industry has averaged 1.75% (see attached chart). With that narrow margin, if the premium cap is set too low and carriers are unable to cover submitted claims, insolvencies will occur.

Premiums will be limited at the same time new and unpredictable demands are being made on health plans and insurers. Insurers will have trouble predicting their expected costs because the following factors will not be known ahead of time:

- How much care will the formerly uninsured use once they are insured?
- Whether the risk adjustment mechanism will adequately protect the plan against a greater-than-average proportion of high-cost enrollees?
- What assessments will be imposed by the various guarantee funds that will be set up to protect consumers from insolvencies?

COMMUNITY RATING AND OTHER COSTS IN THE NEW SYSTEM

The administration's plan envisions the use of pure community rating to determine premiums establishing separate rates to reflect family status. Community rating will increase premiums for younger, healthy workers and low-risk people who make healthy lifestyle choices, for example, non-smokers. Why should those who exercise regularly and don't smoke pay more for their coverage to subsidize those who smoke two packs per day? The young, who are least able to afford coverage and tend to use the system less end up paying more in the new system.

Regional alliance members will have to pay higher premiums to subsidize the additional costs of:

- underpayment by the government for Medicaid eligible;
- bad debts of people who don't pay their premiums (health plans cannot drop people for non-payment of premiums under the Administration's proposal);
- people who are currently enrolled in state-operated high-risk pools;
- early retirees no longer covered by their employers' plan.

As this Subcommittee is well aware, privately-insured patients pay higher prices in order to make up both for uncompensated care (the uninsured) and undercompensated care (Medicare and Medicaid). Universal coverage will all but eliminate uncompensated care, but the Administration's proposed method of financing its proposal will make Medicare underpayment much worse than it is today. We see no evidence that this effect has been taken into account in the Administration's estimates of likely premiums under its plan.

LONG-TERM CARE

HIAA is pleased to see that the Administration supports several provisions which would clarify the tax treatment of private long-term care insurance. These changes would greatly increase the affordability of these products and help millions of Americans protect themselves against catastrophic long-term care expenses.

If the Administration continues to promote the tax changes we seek, HIAA would also support the creation of federal standards for long-term care insurance products. However, such standards must not be so onerous that they prohibit all but "cadillac" policies from being sold. Equally important, consumers should be allowed to purchase federally-approved policies in all states; separate state approval should not be necessary.

We have two concerns with the newly proposed national home care program. First, a far better use of limited tax dollars would be to target care to those unable to protect themselves, and encourage those who can afford to do so, to purchase private protection. Secondly, we are concerned that the Administration will "sell" the public on this program as a down-payment toward a national solution to long-term care when even this modest home care benefit is estimated to cost \$80 billion over five years. Costs alone dictate that the ultimate solution must be a public-private partnership.

TRANSITIONAL INSURANCE REGULATIONS

The transition to a new health insurance market could take several years, especially if the new market structure is as unnecessarily complex and unwieldy as the President proposes to make it. The Administration has proposed, according to their "Working Group Draft", a set of regulations to govern insurers' behavior during the transition. While the Administration's intent is not clear in the drafts we have seen, we would oppose any attempt to prohibit insurers from withdrawing entirely from the health insurance business or any significant part of it, such as the individual market or the small group market. In a free country, government should not coerce any corporation or person to continue in any particular line of business.

Some of these proposed rules we would support. In fact, they closely parallel insurance reforms we have been promoting at the state level for several years. I refer here to such requirements as guaranteed renewal of coverage, automatic acceptance of new entrants in currently covered groups, and portability improvements which prohibit exclusion of coverage for pre-existing conditions when previously insured people change jobs or their employers change carriers. These reforms can be implemented very quickly, and do not require a new bureaucratic structure the President proposes.

Other proposed transition rules present severe difficulties for insurers. The rules establish de facto premium caps by giving states the right to approve or disapprove rate increases in excess of a yet-to-be-prescribed percentage. For reasons explained earlier in greater detail, we oppose limiting insurers' ability to charge rates sufficient to cover the real costs of serving their enrollees.

Also, there are administrative problems with the proposed interim rating structure. It differs significantly from the rating reforms that have been enacted in more than half the states in the past three years and will therefore require significant time and administrative effort on the part of both states and carriers to implement, all for a scheme that would remain in place for a year or two.

In conclusion, I want to again emphasize that we support more of the President's plan than we oppose. We want to be a responsible participant in the national health care debate and want to work with the Administration and Congress to develop national reform which achieves universal coverage, promotes individual responsibility and cost containment, preserves choice and maintains the quality of our health care system. During this discussion, we must remember that our health care system has many excellent features and we should build on them.

Chairman STARK. Thank you.

Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman. I guess I would ask this question of all of you. I asked it of the last panel.

On October 5 HHS Secretary Shalala, in front of the Energy and Commerce Committee, described the National Health Boards as a minor oversight board within the Clinton plan. I guess collectively, would you agree with that assessment given your knowledge of the Clinton health care plan, that the National Health Board is, in fact, an oversight board? Does anyone agree with that?

Mr. ENGLISH. I would certainly not agree with that. I have read the 239-page document and the National Health Board that is described in that document is given very broad powers, including the power to set the price of the standard benefit plan and to allocate global budgets to different regions. This does not seem to me to be a minor oversight role.

Mr. THOMAS. I am still puzzled by her statement. I hope it wasn't flippant, because we are dealing with a serious problem, and for her to assume that it is a minor oversight board boggles my mind.

Mr. English and Mr. Rolland on insurance questions, I am a little puzzled by your strong advocacy of HIPC's to control prices for small business. Mr. Rolland, you indicated that you would like to see a voluntary structure. Here is my question. We are looking at economies of scale and I guess I am looking for another reason why you see, Mr. English, enormous advantages in HIPC's.

I understand the economies of scale that drive down the prices, but what you are doing is setting up, to give an analogy that makes sense to me, an exoskeleton. Since the individual company can't get the economy of scale, you are going to set up a bureaucracy to get it. The problem is you don't like the Clinton bureaucracy, but any HIPC is going to be a bureaucracy set up to try to deliver the economies of scale that the large corporations have.

Why wouldn't you rather, as someone who at least in the Clinton plan looks like the industry is basically going to disappear, be advocating an internal skeleton? That is, if we could get a general idea and you folks know because you negotiate prices with the Fortune 500—if you could set up a composite Fortune 500 regional target model price and figure out how you make the administrative adjustments to deliver that price to the small business person, you don't need the HIPC as an exoskeleton to create the competitive powers small folks don't have individually. It gives you a reason for continuing to exist and in fact performing administrative functions that, to a certain extent, you have abrogated now because you haven't been required to do it—but if the government is going to dictate the fact that no one is excluded, that the benefit package is going to be the same, why are you punting on one area that would give you a continued role in the system?

Mr. ENGLISH. I don't think we are punting. I think we have a different view of the HIPC than what is in the administration plan and maybe a different view than is in the common—

Mr. THOMAS. Would yours be mandatory or voluntary?

Mr. ENGLISH. I would opt for mandatory. Some companies think it should be voluntary. We think the major problem with our

health care system is the inefficiency of the market with respect to small employers and individuals.

Mr. THOMAS. I understand that. It is the economies of scale and inefficiencies, but why are you passing that up?

Mr. ENGLISH. It is more than that. It is a question of an efficient competitive market. Envision a supermarket—

Mr. THOMAS. I have read all the models. Let's not use the kind of analogies that are out there. Just give me a response to my question and I will better understand where you are coming from. Why don't you as an industry want to be able to provide all of the benefits of a HIPC internally in terms of your adjustment for a small purchaser? Or do you think it is impossible for the insurance industry to do that internally?

Mr. ROLLAND. Could I try that? First of all, I would emphasize the HIAA does support only voluntary HIPCs. We believe there may be some merit in these HIPCs in terms of their ability to concentrate purchasing power, but we believe they are untested and we believe they have to win in the market place and we shouldn't preordain them as winners through legislation.

Our view is if they are as good as people say they are they could win in the marketplace and ought to be tested that way.

Mr. THOMAS. In a voluntary structure you are requiring them to prove themselves. If you make it mandatory I think an industry that is desperate under the Clinton plan wouldn't want to mandate an exoskeleton providing adjustments that I would think would allow them to continue internally. I am out of time.

One question to the Blues and perhaps HMOs. This business of the Clinton plan setting up these alliances and dictating the global budget, it looks easy on paper, but basically how many of the companies over 5,000 were going to stay separate?

Apparently, they will all come under the program anyway. Can you imagine how we are going to set, first of all, the first target and what happens if you don't reach it and the enormous dislocation of the adjustments that occur—they got to hit you—if you make the decision, and it is wrong? Given the billions of dollars that are at stake, the couple of percentage point miss is enormous. If you miss it the first time, what do you have to guarantee it the second time?

You are going basically from group insurance with these large companies to individual structures and it is a different world in terms of assessing what is going to happen and then everybody gets to change after 1 year. You miss the target and everybody is unhappy and they change. You have a whole new model to have to price.

How comfortable are you with the ability of the Clinton model to be fairly close to the targets?

Ms. LEHNHARD. We are very concerned about that. You have a macro and a micro issue here. On the micro level, how do you in the first year set your average per capita costs in an area. You have many things going on. You have a pent up backlog of care that is needed. You are moving to community rating. You have so many things going on at once that you don't know how it is going to affect utilization patterns.

At the microlevel, the decision on spending by region is being made in Washington. They hope it is the right amount of money going the right places to cover the costs that are needed. If it is not, the States and the alliances will be in the position of telling health plans here is x amount of money. We know it is not enough to do what you need to do, but try to do it anyway. That is not a sustainable strategy.

Mr. THOMAS. Apparently overseen by someone who thinks the National Health Board is a minor oversight board. Thank you, Mr. Chairman.

Chairman STARK. Let me see if I can make a first step toward the President urging us to get together and see what we can do to find agreement among all the players in this. I take it that each of you endorse competition, am I correct?

Mr. ENGLISH. Correct.

Chairman STARK. And you would all be perfectly willing—you represent slightly different groups—to compete one with the other without government interference, right? Is there anybody who doesn't want to compete with anybody else at the table?

Ms. IGNAGNI. Mr. Stark, I would say from the standpoint of our industry, what we have asked for is government intervention to the extent that we would ask government to create a level playingfield that we do not have today in the market.

Let me be specific what I mean. There are existing practices in the market today; namely, preexisting condition limitations, waiting periods, et cetera, that are difficult in a competitive situation.

Chairman STARK. I think everybody at the table will sign on to that. None of you wants to keep medical underwriting anyway. So we will spot you that. Are you willing to compete with those other folks?

Ms. IGNAGNI. Absolutely.

Chairman STARK. Now, how about making a fifth seat at the table? Will you compete with me? Anybody afraid of Medicare?

Ms. IGNAGNI. We are competing with you in the HMO industry.

Chairman STARK. Do you mind?

Ms. IGNAGNI. We are delighted to do it.

Chairman STARK. Half of them work—the Blues——

Ms. LEHNHARD. By that do you mean encouraging the public to enroll in Medicare?

Chairman STARK. Let us offer it, let us compete.

Ms. LEHNHARD. We continue to think that the Medicare program based on a classic fee-for-service model is not a model we want to perpetuate in any way. We ought to be moving Medicare into the managed care environment.

Chairman STARK. You are going to let the public decide. If I play by the same rules you do, will you let me compete? Yes or no?

Ms. LEHNHARD. No.

Mr. ROLLAND. I think if the rules of the game are the same with everybody it might be worth a try. I would have to see more details.

Chairman STARK. Mr. English?

Mr. ENGLISH. As long as the government has the ability to set prices, it would be very difficult——

Chairman STARK. I didn't say that. Because we set prices for Medicare?

Mr. ENGLISH. Yes.

Chairman STARK. What if we leveled the playingfield and set prices for everybody, used the Medicare system as some of us have suggested. Then do you mind competing with us?

Mr. ENGLISH. I think if you set prices there would be no competition.

Chairman STARK. There seems to be competition now with us and HMOs. It is interesting, you have a strange definition of competition. It is competition where you are the only ones in the market and you exclude the other guys. I have always heard these free enterprise people saying we will beat the government. Those lazy bureaucrats can't do anything. You guys are running like a bunch of chickens except for Mr. Rolland, who is in the West where competition really got started. Didn't it, Mr. Rolland?

Mr. ROLLAND. That is correct. I think if you level the playingfield we could do well against you. That means that everybody pays; the cost shifting is ended.

Chairman STARK. I notice that generally the four of you all agree that the underwriting should be severely restricted or eliminated—I don't know if you go exactly that far—and that probably you would buy into an approach toward community rating and particularly if it were phased in over a long enough time, but it wasn't an abrupt universal. Fair enough so far?

Nothing else that you have all talked about, except you are all for cost containment, but you are rather vague there and you are certainly not agreeing, and you certainly don't want me to do anything. You want to do it all by yourselves.

Mr. Rolland has a reservation on that, I know, because of cost shifting, but what if there were our result in this bill? You might worry that your clients won't stay with you very long if you let me compete. We will do the insurance reform that the insurance industry could generally live with, no more underwriting, open enrollment, those sorts of things, and move toward a community rating structure, and then we just say that is fine and Medicare will continue to go along as they do, and my guess is we would subsume Medicaid into Medicare and probably toss CHAMPUS in.

Will you be content then with the system?

Ms. IGNAGNI. Are you implying that there would be comprehensive benefits for all Americans across the board?

Chairman STARK. You take your chances as to how you get them, but yes. It might be a voucher to individuals or an individual mandate with a subsidy. It might be helping small employers, or letting big employers continue in their present plan, negotiated by union, whatever is out there. If that is all we did, you would be comfortable?

Ms. IGNAGNI. I would like to distinguish myself as an individual who would raise some questions about your proposal—I think now that I understand where you are going. We believe that—the first principal for us is that we have—based on an explosive growth in HMO enrollment over the past 10 years in the absence of any major legislative change at the national level, we have gone to a fourfold increase in 10 years and we think that is going to con-

tinue. We are for the principle of consumer choice so we are very comfortable with the way you posited that question.

I need to also raise the issue of the infrastructure and the cleaning up of very conflicting standards. I think although it sounds very technical and somewhat boring—

Chairman STARK. That is not before us.

Ms. IGNAGNI. It will be before you if you want to assure consumers that there is a good housekeeping seal of approval so in effect there are qualified plans out there in the market—

Chairman STARK. We can't put Metropolitan Life in jail for crummy marketing practices, like Pericles that stole \$12 million and they show up again in Texas. Let's stay with what we think we could do in health reform.

What I am saying is I am not sure that the rest of the public and the country could survive without cost containment on the public side, and on the private side. We have it in the public side and it works, but it shifts costs on to the private side and the major corporations, I think, would give you guys about a year when they figure out what happens, particularly if we add \$100 billion or more of cost cuts on the public side.

While it may not affect your businesses, your clients, I think, would be giving you what for.

I don't know as there is any agreement among you as to how we could control cost.

Mr. ENGLISH. I accept the competitive challenge that you have described as long as all payers in the system paid their fair share. But so long as we have one system such as Medicare in which people have freedom to have what they want without regard to the consequences of cost, to use an example that came up somewhere else, they could go to the Mayo Clinic—

Chairman STARK. They also have the freedom to join a HMO.

Mr. ENGLISH. And they have the freedom to be in Medicare and go wherever they want, do whatever they want, whatever their doctor thinks is appropriate so long as they pay for it. As long as they paid the full cost of that, I could compete quite effectively.

Chairman STARK. As long as they pay what full cost? They have an insurance plan that is less generous than most of yours. Medicare is not very generous.

Mr. ENGLISH. They are the same.

Chairman STARK. No, they are not. Medicare benefits, if you will pardon me, are around the 15th percentile and Mary Nell's Blue Cross low option is the 85th percentile. We have no limit on copays. Every plan I bet that you sell has an out-of-pocket limit.

Medicare does not and that isn't very generous. All plans are the same in terms of the benefits they provide. It is a matter of deductibles, and copays. So Medicare leans heavily on the private insurance industry, and the generosity of Medicare is not great. So I don't think that is fair to people who decide to go to the Mayos and could spend tens of thousands of dollars whereas, they may not have to under some of these plans.

Mr. ENGLISH. I suggest that whatever it costs, and there is growing empirical evidence that plans that allow people total freedom of choice cost more than managed care plans do. As long as everybody pays their own share—

Chairman STARK. The managed care plans aren't that good and the people are getting smarter and they figure they know where they want to go. They are getting sick of being told they have a shabby list of doctors that can't make a living in a good system, so they are shoved into limited areas, particularly if they are poor and minority and on Medicaid. They get the short shrift of the butcher shop hospitals and really bad doctors and it doesn't take the public long to figure out who is gypping them, so I would give the public some credit even if they don't read consumer reports for figuring out how money is being saved.

It was Kaiser who said they kept the costs down by cutting benefits. It doesn't take a rocket scientist to figure that out. You have just answered my question. I was going to suggest that none of you would submit that your plans have any more choice than Medicare. None of you would suggest—Mr. English, you have answered the question—that your plans that are offered to the public don't have more choice than Medicare. Another way, Medicare has more choice for its beneficiaries than any other plan offered in the marketplace today.

Mr. ROLLAND. It certainly has broad choice.

Ms. IGNAGNI. Mr. Chairman, I would say that Medicare beneficiaries, although on paper have unlimited amount of choice, in effect they have no boat to navigate through a very complicated delivery system. I think that that is the point you will have to wrestle with in terms of making improvements to that system and then moving to the system that we have now—

Chairman STARK. Dr. Todd, might explain to you how he might challenge you on that and say would you rather trust an M.D. or an MBA to navigate you through that thicket.

Ms. IGNAGNI. I won't speak for Dr. Todd, but I would be happy to engage in that debate. But I would say that as a consumer, as a mother, the thing that scares me most is the promise that people brag about the notion of being able to choose a doctor from the phone book. I think that is what you have under Medicare. I respectfully submit that that is not the right situation. People don't know how to evaluate quality and that is the long-term issue for us.

Chairman STARK. I guess that is true, but what I would submit then, and I hate to quote from Mary Nell's testimony, but I don't think the insurance companies know a lot about quality either. What they know about is, as she says here, it is easier for insurers to hold down costs by screening out high risks than by managing overall health care costs and goes on to prove her point.

What I think insurance companies are very good at doing is red-lining, deceptive marketing practices, and making a lot of money by squeezing benefits out of plans. Their record is clear on that. I am not sure that those are the folks I want taking care of my constituents, because the social record of insurance companies is abysmal, almost as bad as Members of Congress.

Mr. ROLLAND. Mr. Chairman, if I could, I would submit that even before this debate on health care started at the national level, our industry developed a significant concern about some of the practices you are talking about.

Chairman STARK. I know that.

Mr. ROLLAND. And developed our vision statement that called for substantial reform in that insurance delivery system and had been advocating that and pushing that at the State level for quite awhile. In fact, 40 States have adopted significant insurance reform practices, and so we have been advocating that.

We are as concerned as you are about some of the practices that have gone on in our industry and we are trying to do something to fix that up and are supporting strongly the aspects of the proposals we see on the table that are consistent with that.

Chairman STARK. Let me make one comment about California, and this does not have anything to do with the fact that you are running it, but my concern—the California HIPC is different from other HIPCs, I understand.

We have over 5 million uninsured in California, and after 3 months, and that is a fairly short time I must admit, we have only enrolled 15,000 of those 5 million uninsured. At that rate, it will take us about 80 years to get the uninsured in California into a plan.

Seeing as 17 of the 18 plans have costs far higher than what the President is suggesting, which people are already saying is too generous, I just have some question if that alone is going to do it. We are going to have to provide those folks some money to buy into the plan. I don't think you can squeeze a lot more out of the plan in California.

Mr. ROLLAND. I certainly agree with that. I don't think a voluntary HIPC in California is going to solve your uninsured problem. There have to be other approaches. Certainly people who are poor and indigent and small business owners have to be subsidized in their ability to get that insurance.

Chairman STARK. I agree. Dr. McDermott.

Mr. McDERMOTT. First of all, let me ask Miss Lehnhard and Mr. English and Miss Ignagni, do the members who participate in your plans do it voluntarily?

Ms. IGNAGNI. You mean individuals, consumers?

Mr. McDERMOTT. Yes.

Ms. IGNAGNI. Yes.

Mr. McDERMOTT. Mr. English?

Mr. ENGLISH. There are a variety of health plans. Some circumstances employers will pick one HMO with one main indemnity plan. They will also offer other choices.

Mr. McDERMOTT. So if an individual employee chose your HMO out of a series of other things that were offered, so they voluntarily joined—

Mr. ENGLISH. A series or the ability to opt out for fee-for-service type coverage as well.

Mr. McDERMOTT. The same is true of Blue Cross and Blue Shield. Ms. Ignagni raised this question—this is a question that has been in my mind for some time, so I want to ask you, Mr. English and Ms. Lehnhard—do any of your plans involve themselves in the managed care proposals related to Medicare, the 30 million people in Medicare, 2 million of them are in managed care.

Mr. ENGLISH. We do.

Ms. LEHNHARD. Yes.

Mr. McDERMOTT. So all three of you have people who are in managed care in this present system under Medicare. It seems to me that that confirms in operation in this country that it is possible for both managed care and the fee-for-service system to operate under a single payer plan. Medicare is a single payer plan.

It is the only operational one in this country that works for senior citizens, and there you have both senior citizens choosing, some to go into managed care, some to go into the fee-for-service; so they have the maximum range of options under the Medicare system.

What objections do you have to a single-payer financing system for the health care system in this country?

Mr. ENGLISH. A single-payer system to me, as I understand the term, is a government takeover of 15 percent of our economy. It does not need to be done. It would cause massive disruptions.

It seems to me that if it were done, it would be done with a tremendous amount of political pressure on promising benefits. A tremendous amount of political pressure to fix the prices. The ultimate consequence of that would be an initial significant deterioration in quality, followed by cost overruns. It would be a disaster for our country because it would lack the element of competition that I think is so vital to our system.

Mr. McDERMOTT. But you have that competition in Medicare today.

Ms. LEHNHARD. I would say that we don't think you have it to the degree you need it. We have dropped significantly our participation the Medicare risk business because of what we consider arbitrary actions on the part of Medicare that you wouldn't see if this were true competition in the private sector. I think we are down to about a third of the plans that started out—

Mr. McDERMOTT. Tell me what the arbitrary actions of Medicare are.

Ms. LEHNHARD. Cuts in the payment rate in Medicare.

Mr. McDERMOTT. You mean not increasing as fast as you want them to.

Ms. LEHNHARD. Actual cuts. Changes in the—I will have to get back to you with specific examples, but I hear this concern from our plans—changes in the rules, constant changes in the rules. It is very different dealing with the government. What they are most struck by is lack of innovation and lack of creativity in a huge bureaucracy that has to follow one rigid set of rules primarily.

Ms. IGNAGNI. Mr. McDermott, I would answer the question in the following way. I think it is a very interesting one. The issue of the Medicare formula, this is a corollary to Mary Nell's point, has been a very difficult one for plans that have participated in the system. She is right, there has been some frustration because we have found that because of that formula system, which could very much work like the proposed premium cap system, there have been some difficulties in actually providing what is considered to be a fair payment for the price of delivering services to the particular population group.

Because of technical problems in the formula, because of the way that is structured right now, there has been a decrease in the amount of money and a reduction, zero increase to some of the plans that are in the largest highly penetrated managed care mar-

kets. I will say that HCFA is in the process of trying to deal with that and working closely with us and I think other members of the panel in trying to reconcile that. But some of the same kinds of problems could present themselves in the premium cap formula that is on the table for discussion under the President's proposal.

Mr. McDERMOTT. So the only objection I am getting from you is technical adjustments in the formula in figuring out what the capitation rates should be—

Ms. LEHNHARD. Technical, philosophical, operational.

Mr. McDERMOTT. Tell me about the philosophy.

Ms. LEHNHARD. The philosophy here is the amount of money allocated; this is all you get, it is not true competition. It is just the difference between a massive bureaucracy approach to try to cap spending and a competitive approach where the market sets the appropriate level of spending.

Mr. McDERMOTT. Medicare uses about 4,500 people who cover the whole country. So we are not talking massive bureaucracy. You are saying that you can't accept the idea that there is a single payer that pays capitation. It seems to me that is what you have today.

You operate on a capitated care basis in your plans. Somebody gives you \$109 a month per person or \$143 a month per person. Why do you care where that money comes from? Why does it have to come from 1,500 insurance companies, with all due respect to Mr. Rolland?

Mr. ENGLISH. Today we have the freedom to compete and the freedom to choose. We can look at the HCFA reimbursement rates. We can look at our own ability to control hospital days and cost confinement. We can put together a packaged program, and if we feel we can make a profit on it, we can be in that marketplace. If we don't, we can withdraw from that marketplace.

If there were a single payer throughout the country, we would have no choice. We would have to live with the price control that was installed or go out of business.

Mr. McDERMOTT. So your argument is you get different kinds of dollars in Boeing and from Westinghouse or General Electric, and if you don't like the General Electric dollars because they are purple instead of green, you have a right to reject them, but if you had a single payer all the dollars would be green and you don't like them all being green.

Ms. LEHNHARD. I think from the General Electric perspective—

Mr. McDERMOTT. Never mind General Electric. I want to talk about your perspective.

Ms. LEHNHARD. It is not so much that we turn them down, it is that they make a choice based on competition and we are not constrained by very strict rules on how we do our day-to-day operations, like for example, the constraints you have in the Medicare program.

Mr. ENGLISH. It is not the source of the dollars or the color of the money. It is a question of in a free market—for a free market to be able to operate, buyers have to be willing to buy and sellers have to be willing to sell and an equilibrium price has to be reached. That is the way free markets operate.

If you are dealing in a market where the government dictates a price, you have no choice.

Mr. McDERMOTT. If they deliver a \$4,200 check to one of you, I can choose which one of you gets it, what difference does it make to you where that \$4,200 check came from?

Mr. ENGLISH. No difference.

Ms. IGNAGNI. I think in principle, the answer to your question that we are all giving is that were the Congress to decide that the direction they want to go in is a single payer, that we would all compete in that market and consumers would choose.

However, I think the point that we are getting to is more fundamental to the current discussion, which is what would be the terms and conditions and how would the system be organized. I think as we look at elements of the President's proposal, we are concerned about the picking and choosing of a regulatory structure in the market and actually preventing one aspect of a delivery system being out there in the market offering services that could theoretically limit consumer choice. That is a major point that I think has been made throughout the discussion here.

The second thing is that is it prudent for a regulatory structure to take over some of the new initiatives that have been developed by practitioners in the market in terms of report cards and quality and things of that sort. I think we will have to discuss that further.

I think you are hearing some concerns about the reach of a regulatory structure, whether it be in a single payer world, an alliance world or some other world that hasn't been on the table. I think that is what the debate is going to be all about.

Most certainly our plans will be competing in whatever world is possible and I think everyone is saying that we stand for the principle of consumer choice. The question is how do you design the overall structure and is it such that you prevent plans from participating in the market?

Is it so tightly regulated that in fact you don't have the consumer choice that would be promised on paper? That is the issue.

Mr. McDERMOTT. We are looking today at the 800-pound gorillas. These are the folks who are going to deliver the health care in the President's plan.

Ms. IGNAGNI. In any plan.

Mr. McDERMOTT. You know that the development of managed care is going on in this country at a helter skelter rate. The Sisters of Providence in Seattle are buying up doctors' practices all over the place, putting together networks. Doctors are trying to sell their practices to big insurance companies. It is going on at an alarming rate without most people being aware of it.

But what you are asking for, it seems to me, by saying that you want the President's plan is that you want a system put into law which will herd all the Americans through financial incentives into managed care. That is basically what this law does for you. If this law passes, if I charge somebody \$1,500 more to be involved in a fee-for-service system than I do for one of your three plans, then for a lot of people they will come to you whether they want to or not.

They are going to be forced. My first point was everybody now in your organizations are there voluntarily. None are dragged kick-

ing and screaming or forced financially to come to you. But inherent in the President's plan financial incentives which drive them all into your corral. I understand why you like the plan.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON of Connecticut. Thank you. Before I go to my questions, I would like to ask you to submit for the record materials that enlarge on this issue, the ways in which the rules under which Medicare functions prevent you from innovating in a way that reduces costs and improves quality, prevents you from responding to quality issues or care concerns that individuals have, and any other aspects of the rigidity of Medicare, because I hear this all the time.

[The information follows:]

The following are examples of additional regulatory requirements and administrative oversight which make participation in Medicare risk contracting more burdensome and may discourage managed care organizations from entering this market:

- limitations on the terms and conditions of relationships with providers, commonly referred to as the "incentive payment regulations";
- additional requirements for classification as a federally qualified HMO or CMP;
- problems with the methodology for rate setting of the area adjusted per capita cost (AAPCC); and
- limitations on out-of-area coverage of participants in risk contracts.

Mrs. JOHNSON of Connecticut. Fifty percent of my caseworkers work is advocacy with Medicare to try to get what recipients ought to be getting anyhow. So I don't see single payer as offering either the flexibility, quality or cost control that we need.

But I think we need a better understanding of what are the problems under Medicare now and how does it cut out innovation and how are rigid rules backfiring on the people—I understand how the rigid rules around the formulas have created cuts in reimbursement rates in the very areas where we were supposed to be increasing reimbursement rates.

So I think we need a better understanding of that, because if we are going to go to a system where the national government is the only payer, we will also have behind that a whole set of national rules and all the problems that we have in Medicare. We have to be willing to deal with that on the scale that we would have to.

What interests me most is when the First Lady testified before us, and everything she and the President have said and everything most of the serious groups concerned with health care reform are saying from the single payers right on down to the House Republicans is that we have to reorganize how we deliver health care services.

Now, you offer us the first real opportunity that we have had to look at this issue of service delivery reorganization and capital investment. I would like you to be as specific as you can about what capital investment is required, what are some of the kinds of accomplishments that new investment have achieved. I was very interested, Mr. English, that you say we are moving toward a paperless health care system.

It sounds like what the single-payer folks are saying. What is the role of capital? And what will be the availability of capital under a premium cap versus a tax deductibility limited system?

Mr. ENGLISH. The question of the innovations first. Managed care, as we operate as CIGNA and as I know all the members of GHA operate, is a partnership among the provider, the payor and the patient. The objective is to keep the patient healthy. When they get ill or are injured our objective is to get them well again in most cost efficient way. Everyone in the system has the incentive to do that.

As a consequence, we have seen innovations in our health plans in the treatment of pediatric asthma patients where we have been able to demonstrate a significantly more cost-effective way of treating these patients and also a significantly lower cost of treating those patients. We have been able to identify in all our plans women who are high risk pregnancies and eliminate a number of premature births, again I submit a higher quality result for the patient and significantly lower cost for the system.

In the area of administrative services, the technology exists today and is rapidly being rolled out by our companies and others to give everyone a smart card. With the smart card technology in the providers's office, we will be able to transmit the data and funds electronically. These innovations are taking place as we speak.

And as long as we have a system of free market competition in which a profit is available, and profits are only earned when you add value—the capital will be there to fund these innovations. Capital will also be available to fund the restructuring of the system. It is essential that there be the opportunity to operate in a free market. We can not be saddled with price controls or premium caps.

Mr. ROLLAND. I might comment on this from the standpoint of the insurance industry. The National Association of Insurance Commissioners is currently in the process of establishing minimum capital requirements that we have to hold with respect to all the risks we take.

Mrs. JOHNSON of Connecticut. Excuse me. Do those capital requirements apply to self-insured companies as well?

Mr. ROLLAND. No, I am just talking about what the insurance company has to hold against the risks that it insures. This wouldn't have relevance to a self-insured employer.

Those minimum capital requirements, I believe, go into effect the first of the year. They will apply to health insurance, so they will define a certain amount of capital we have to hold behind the risks we take. That means our shareholders put up that capital.

In order to justify being in the health insurance business, we have to earn for them at least what they view as their cost to capital. In our view, that means we have to earn over a period of time something in excess of 15 percent per year on the capital that we invest in this business.

That is what we have to earn in order to be able to attract capital to it, because we have other options that we can use for our capital. In addition, this business is becoming much more information processing sensitive. That requires the establishment of fairly complex computer and administrative systems, all of which require investments upfront that are recovered over time out of the business you do.

That is just an additional capital contribution that we have to make to this business.

So as we move more to managed care and more to recognizing the risks that are involved in that business, it has required us to put up more capital and therefore be more sensitive to our ability to earn on it.

Ms. LEHNHARD. An example of why capital is so important, back in the old days when we first started looking at how to control costs, we focused on price and we went out and negotiated with physicians all over the country, at significant cost to the plans. I think about 80 percent of physicians entered into contracts with us to pay reasonable and customary charges in our private business.

Then we entered the next phase of capital investment to look at physician utilization patterns. We began to look at how they use services in their offices.

In the last 18 months, we entered the third phase, making major investments, to look at physician total resource use both in their office and in other settings. For example, just three plans have invested millions of dollars to develop powerful, new physician profiling tools.

In assessing total resource use, you not only look at the office, you look at what the doctors order in the lab, how they use the hospital, how they use the pharmacy. These other service providers are entities that are completely independent from the physician and it is an enormous task with enormous costs to pull all that information back together—adjust for difference in risk of the patient population—for example you don't want to penalize a physician that treats AIDS patients—and begin to track a given physician's utilization pattern. What we have been able to do with that data, that information on total resource use, is find physicians that use resources prudently.

For example, just on normal deliveries we found a 300 percent difference in total resource use, just in normal deliveries. We have begun to look at overall quality including efficiency.

We have dropped people out of our networks because of early quality indicators. But the next big investment will be to look at quality while working with those physicians. Once we put these physicians in a network, we generally leave them alone. We monitor them, but we don't hassle them.

What we have found is that other physicians in the community are interested in finding out what those physicians are doing to establish them to get into the network. This is what I am afraid GAO won't get to. It is how physicians use resources that is important.

It is not the price. In fact we are willing to pay more for a procedure if they have efficient use of total resources. That is why I worry about the level of capitalization in the Medicare program; because all they have done is focus on price and not utilization patterns.

Ms. IGNAGNI. Mrs. Johnson, I think your question is very germane to the debate and it is one that is rarely asked, and it is going to be essential as we think about developing new capacity and expanding the delivery systems that we have now. Let me try to distinguish what I think we have in the managed care world versus the fee-for-service world, because it is very relevant to your

capital question and my response builds on something Mr. English stated.

In the HMO world we have coordinated systems of care, two things that are very important, the coordination part and systems part, so they have all the internal review procedures that are necessary to feed back information about quality, emphasize prevention, go out and remind people that it is time for mammograms, go out and remind people that it is time to bring your children in, remind people over 65 that they need to get flu shots.

The investment is very much on the front end, but it is a considerable investment. We are the only delivery systems that are organized in a way to provide efficient and effective care. The base is very lean.

There isn't the fat that the President talks about in the system as exists in the fee-for-service system. I think when you deal with the notion of premium caps and you pose the question about what will be the capital implications, in delivery systems that are running in a very lean and efficient way that implication or that effect could be considerable and we are worried about that, which is why we want to raise the issue early enough so we can offer some helpful suggestions.

Just the reserve issues and the holding of capital as you expand capacity are very considerable, and that is a matter that we haven't considered much in the current debate, and we need to.

Mrs. JOHNSON of Connecticut. Thank you. I appreciate your answers.

What I hear you saying is that, though investing capital, you have been able to look at issues that we call outcomes research, move that further into total resource use, look at the very kinds of things government has said we ought to be looking at, but that government has made a very limited investment in itself, and in its own systems has made practically no investment.

I think it is significant that in spite of the fact that you have to make a return to your investors on their capital investment, you are actually cutting costs the right way by improving quality more aggressively than the government is.

We have in the VA system, specifically where we have absolutely total control, and we could have done the kind of investing that you have been doing. We cut costs by excluding by law groups of veterans from access to that system. In the VA hospital in a town adjacent to my district, we have controlled costs by reducing services to the extent where if you live in Connecticut and you need a hearing test, you have to go to New York City.

So I think it is very important for people watching this hearing to understand that change is going to require capital investment; that change brought about by government has not involved capital investment to any significant degree, and instead by price fixing and capping budgets has reduced access and affected quality.

I think this is an aspect of this issue that we have to investigate in far greater depth if we are going to come to the right conclusion.

I also would like to thank Mr. Rolland for his comments about what it is going to do to the industry, because once you do under the administration's plan, you force all the self-insured people to go into health alliance programs. There will be a sucking sound that

we will hear very clearly that will affect jobs in the private sector because it will move capital from private sector investments into being set aside capital in the insured industry.

Chairman STARK. That is tomorrow. Mr. Levin.

Mr. LEVIN. Mr. Rolland, I am not clear on the association's position on alliances. You talk about competition and the alliances controlling who would compete and who would not. You suggest that this does not seem consistent with the goal of consumer choice or the goal of competition.

So clarify, if you would, on what basis, if we have alliances, do you think others should be able to compete?

Mr. ROLLAND. As our testimony says, we believe there may be some merit in the alliances so we don't oppose them altogether. But we believe they should compete in the marketplace along with other forms of health care delivery. This would involve competition by insurance companies, other health plans, HMOs, a whole variety of other ways of delivering health care to individuals.

And we believe that the alliances are as good as some people think they are, that they will win out in the marketplace. So we don't believe that the Congress should dictate this by legislation.

Mr. LEVIN. Let me press you, if I might, because I think we all need to go beyond the most appealing rhetoric and try to get to the heart of the matter. Let's assume, in theory, you are correct. On what basis would those outside the alliances compete; for example, in terms of risk selection would they be able to do any of that?

Mr. ROLLAND. No. Outside the health alliances they would have to compete on exactly the same basis as the alliance.

Mr. LEVIN. So that means there would be strict community rating, with no regard for whether people smoke or their age or anything else.

Mr. ROLLAND. Whatever rules apply for the alliance. Now, we have some problems with absolutely flat community rating, but if that were the outcome of this legislation, and those rules applied to the alliance, they would apply outside the alliance as well.

Mr. LEVIN. So—

Chairman STARK. Would the gentleman yield?

Are you talking about accountable health plans within the alliance? Because alliances, in my understanding, don't do anything. They have plans.

Mr. ROLLAND. That is correct.

Chairman STARK. We are talking about the plans in the alliance.

Ms. LEHNHARD. They could be both. You could have a health plan that is both an option in the alliance and an option outside the alliance.

Mr. ROLLAND. But competition outside the alliance would be on exactly the same basis as competition inside the alliance, totally level playingfield.

Mr. LEVIN. Well, let me ask you this—there would be no so-called cherry picking, no skimming, et cetera?

Mr. ROLLAND. Correct.

Mr. LEVIN. What would be the economic consequences, do you think, for most of the members of the association if they could do no selecting of risk whatsoever and have to compete with the much larger entities?

Mr. ROLLAND. We are willing to take our chances in that environment. In fact, our industry has already advocated a lot of the reforms in underwriting and pricing and so forth that you are talking about. We particularly believe in an environment where everybody has to obtain coverage, that there would be an ability to get a spread of risk, so we are willing to take our chances in that environment and compete against the alliances. We think that plans outside the alliance could possibly compete on the basis of customer service and on other things that could make them a more attractive—

Mr. LEVIN. What you are saying is that everybody who meets standards should be within an alliance?

Mr. ROLLAND. No.

Mr. LEVIN. Why not? What is the difference?

Ms. LEHNHARD. Everyone should meet the same standards. Say there are 12 insurance companies in a State, one alliance. All 12—

Mr. LEVIN. I am still not quite sure. I think it is often fuzzy because the association sometimes attacks community rating, and the message isn't clear whether you want the present situation to continue, where there can be any form of risk selection by companies or not.

Mr. ROLLAND. Our association is on record firmly as supporting substantial reform in the insurance system, doing away with cherry picking, limiting pricing, moving toward community rating.

Mr. LEVIN. Toward or—

Mr. ROLLAND. Well, we have some problems with total absolute pure community rating.

Mr. LEVIN. So what would be the difference—and I will finish, my time is up—between the companies with whom business was placed by the alliance—

Mr. ROLLAND. None. None.

Mr. LEVIN. So, except for where the check goes originally, you are saying there is really no difference among companies inside and outside of the alliance?

Ms. LEHNHARD. Mr. Levin, one of the big reasons to try the alliance, to have the voluntary alliance, is that is what supports individual selection of coverage. All of the health plans out of the alliance would be selected by employer choice. Employers who join the alliance would say to their 100 employees, all right, I am not going to choose your coverage anymore, each of you make 100 individual choices, so it is an administrative framework to support individual choice.

Mr. ROLLAND. And we are concerned that with an environment of mandatory alliances that ultimately the market will become significantly constrained, there will be far fewer competitors; competition will be substantially reduced, particularly in the long run than under an environment where the alliance can function with health plans within it, but also other providers of health care coverage could function outside and could compete with the alliance. We think that creates an environment where far more competition takes place, and we think that the more competition will be a beneficial factor in controlling costs and making the whole system more efficient.

Mr. LEVIN. OK. Thank you.

Chairman STARK. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman. To the panel I apologize I wasn't here to hear your testimony, so I won't ask you specific questions regarding your testimony, but as long as I have such a knowledgeable group here, I would like to ask your help in explaining to me how the Clinton plan will work. Let me preface this, restating what I understand to be the goals of the Clinton plan, by the year 2000 they are going to save \$124 billion in the Medicare program, and about \$114 billion in the Medicaid program; they are going to expand the universe of insured people to everybody, so that everybody is going to have insurance, and thereby, I would think create more demand on the system. They are also going to have a tobacco tax that will generate \$110 billion or so.

Can you all explain to me how you understand all that is going to be achieved?

Is there really that much waste, fraud, and abuse in the system?

Mr. ENGLISH. I don't believe, Congressman, that there is nearly enough waste, fraud, and abuse to pay for all of that. I think we have overestimated the amount of Medicare and Medicaid savings. I think we have underestimated the increased utilization. I would predict that if this plan were enacted as it appeared in the preliminary draft that the consequences will be the following: the price controls will be invoked. They will be invoked from the very beginning.

As a consequence of that, quality will deteriorate, lines will form, treatments which are readily available today will not be available. Ultimately there will also be cost overrun and you will be forced either to increase the deficit, cut other programs or raise taxes.

Mr. ROLLAND. I would support that totally. From what I have seen in the press about the numbers, it is hard for me to believe they are realistic in any way, shape or form. My personal view is that if a system like this is put in place, that eventually the Congress will have to face up to some kind of broad-based tax to pay for it. It will be a very difficult decision. You know that better than I do, but I think the whole issue of cost and savings and so forth has just got to be dealt with more seriously than it has up to this point.

Ms. LEHNHARD. I think there is also a subtle, until you understand it, then not so subtle form of financing that a lot of people haven't focused on. It has to do with the way the alliance is structured.

Let me give you three examples. Think of the alliance as a big pot of money. Medicaid eligibles are going to come in at less than a dollar, in proportionate premium dollars. Right now you think about States paying \$10 a visit for Medicaid, well below the market rate. We are going to turn around and pay market rates for Medicaid, so States aren't going to be able to afford to pay the full cost of the premium. That shortfall will get subsidized throughout the alliance.

Part-time workers will have part of their premium paid but not all of it paid. That shortfall also will get subsidized through the alliance. There is also a provision that insurance companies can't

drop people because they don't pay their premium. That again will get subsidized through the alliance.

This is a very important strategy to finance universal coverage. It will be paid for by swirling all of the money around in the alliance and asking everybody to share in the cost. It is a huge source of cross subsidies that I don't think, people have focused on yet.

The other way they have made this more affordable is by capping premiums at CPI. When we start to cover people that have never had health care services, we don't know what is going to happen to utilization. We currently don't know how much to cut back for uncompensated care. I think it is a big guess to know whether you can meet CPI or not. We have a feeling it is much above that, given the pent-up demand that we are facing.

Mr. MCCRERY. Miss Ignagni?

Ms. IGNAGNI. Well, I think that many of the assumptions in the Clinton plan with respect to financing are keyed to the premium caps, and if the decision by Congress is to have premium caps that, in fact, may generate some real concerns with respect to quality and adequacy of meeting the needs of a variety of consumers, then I think that a number of the assumptions will have to be looked at again.

Mr. MCCRERY. Well, I hear you saying basically that you don't understand either how the Clinton plan is going to achieve the savings. I left out that we are also going to cut the deficit \$91 billion while we are doing all this. So I hear you saying that you don't understand, either, how exactly the Clinton numbers are going to work. Unless we have rationing of health care, much as we are doing now in the Medicare and Medicaid programs, we are going to be doing systemwide basically, crunching down artificially on the costs, not doing anything about the demand or the supply, and so what you have to do is artificially crunch down on the demand, and that is cutting out services or the only other way to make it work is to come up with some other broad-based tax to finance the costs of this program. Is that a fair summary?

Ms. LEHNHARD. I would like to followup on what I said and say something much more positive, after having said something negative. We are very supportive of the approach in President Clinton's plan, again of insurance reform and eliminating risk selection, which will lead to cost containment based on managing costs. There is a very strong emphasis in his proposal on creating what we think is the most effective way to control costs not through government rationing, but by getting people in networks where physicians make decisions about how you spend scarce resources. We are very supportive of the managed care approach, and that is a cost containment initiative in our view, a very strong one.

Ms. IGNAGNI. I think following up on that there is a very strong emphasis on fully supporting the President's proposal on prevention in the front end, getting people in early. That is going to be the key to the long-term effectiveness of any national health care strategy that is ultimately adopted.

Mr. ROLLAND. We would also suggest there are opportunities for savings. We believe administrative costs can be brought down.

That is already in the process. We also believe there is opportunity for saving and real malpractice reform. We don't see that yet

in the proposals and I would personally like to see it go farther, so there are some opportunities for cost saving, but I think not clearly to the extent that has been advertised so far.

Mr. LEVIN [presiding]. All right, I think the gentleman's time is up if that is OK.

Anyone else want to inquire?

Mr. Grandy.

Mr. GRANDY. Thank you, Mr. Chairman. I was not able to hear the panel's testimony, but Mr. Rowland, you and I did discuss briefly prior to the beginning of the hearing the whole question of thresholds, employee thresholds and mandatory versus voluntary purchasing cooperatives. HIAA, I know, is on record as favoring a voluntary arrangement.

Mr. ROLLAND. Yes.

Mr. GRANDY. The President, as you know, has a mandatory threshold of 5,000. The bill we introduced yesterday has 100. Mr. Chafee's bill has a voluntary threshold, but with a very heavy hammer of community rating for everything outside that threshold, so in a sense I tend to view that as a back-door mandate.

Just so that you know, and we can discuss this on the record, one of the reasons that our alliance of Republicans and Democrats did not opt for a voluntary threshold when we introduced the bill is because we could not find a suitable risk readjustment mechanism that would allow for some of the selection problems, risk adjustment problems, and I am curious to get your views as to how that might be incorporated if we were to change in our bill a mandatory 100 employee threshold to voluntary. What is the proper risk readjustment mechanism to make that work?

And the second question I would like to ask is do you generally agree that if there is to be a threshold, it should be around 100 employees?

Mr. ROLLAND. On the first issue of the risk adjuster, it is difficult for me to sit here now and tell you how I would do that. Certainly the risk adjuster is an issue that relates to even in a mandatory HIPC environment, I believe. We would like to do some work and help you with that. We would just ask you to let us consider that and get back to you.

Mr. GRANDY. I assume that you are not fully embracing John Chafee's solution, either, which would be voluntary but with community rating as the sort of Damocles that falls—

Mr. ROLLAND. Our view is that the alliances should be mandatory and that competition in and out of the alliance should be on the same basis. There should not be an adverse effect on plans that compete outside the alliance.

Mr. GRANDY. But you don't have—were you going to add something here?

Ms. LEHNHARD. I would add that we have done a lot of work on risk adjusters, we have looked at the classic ones where you look at the health status of the individual, his or her medical condition, and all of that—which accounts for far less than half of the variation in cost. We have also looked at the sort of gross adjusters that States are using on a more global basis. I would share that with you, but we are still not done with our analysis. And that is one of the reasons we think you can't jump in to individual selec-

tion for a whole segment of the market; you have to go the voluntary purchasing route. That greatly reduces your need for an effective risk adjuster.

Mr. GRANDY. What about the second part of the question?

Mr. ROLLAND. The second one is a very difficult one to answer. Our position is that they should be voluntary, that there should not be any mandatory aspect of this.

Mr. GRANDY. So you wouldn't cap the number of employees at any particular level then?

Mr. ROLLAND. We would not cap it at any particular level.

Mr. GRANDY. But then don't you run the risk of seeing small groups self-insuring into programs that probably wouldn't be actuarially sound? My concern is that if you start allowing employees, employers with like 25 employees to self-insure, do you really have an actuarially sound health care policy if there is a big claim?

Ms. LEHNHARD. If you say that small group is subject to the same rules as everybody else in the market, that they have to take everyone, then you have an alliance with open enrollment and it is subject to all the other rules. We are saying you can't have self-funded groups that don't let people in. That is where you are going to get into trouble.

Mr. GRANDY. But couldn't it conceivably happen that, given the kind of workplace you would be self-insuring, you get a group of people that might be young, healthy, males and in so doing kind of creating a privileged class by self-insuring as opposed to not putting them into a larger pooling cooperative and having them mix their low risk with some high risk population that would be in these larger cooperatives?

Ms. LEHNHARD. We are saying that it should be a prohibited, that you shouldn't allow 12 groups that have young health people join together. They don't like the fact that there is community rating out there, so they are going to set up their own association. They know they are young and healthy, and they are going to pull out their good risk, so the rest of the pool deteriorates. We say that is the very sort of thing that has to stop or you are not going to achieve any of your objectives of community rating.

Mr. GRANDY. Your contention is you don't need a mandatory requirement with a pooling threshold of employees to get that. You can get that through voluntary pooling arrangements and laws against adverse selection.

Mr. ROLLAND. Health plans that operate outside the alliance have to follow the same rules as those inside the alliance.

Ms. LEHNHARD. Let me give you one example that might help. Suppose you have an insurance company, it competes outside the alliance and it has a community rate of \$100. It also says I am going to do business with the alliance because that is where employers who want individual choice for their employees have to go, but I am also going to offer them my community rate of \$100, so they are offering it in both settings. But they have chosen to participate and compete both in the alliance and outside of it.

Mr. GRANDY. OK. Well, let me just conclude, Mr. Chairman, by saying if there is a way that you can come up with a workable, practical, understandable risk readjustment mechanism, I am sure

our group will be willing to consider it, so we look forward to hearing from you in the future.

Mr. ROLLAND. We would like to work with you on that.

Mr. GRANDY. Thank you, Mr. Chairman.

Chairman STARK [presiding]. I am sorry I was out of the room at your questioning, but I gather you just dealt with the risk adjustment issue and whether it exists in reality.

Mr. GRANDY. Not directly to that, Mr. Chairman. I was just asking Mr. Rolland if there is such a thing as a workable risk adjustment mechanism to allow voluntary as opposed to mandatory pooling arrangements. The belief of the panel, I believe, is there is, they just don't quite have it yet. I don't want to misstate anything there, but that is essentially what I have heard publicly and privately.

Mr. ROLLAND. We certainly would be willing to work with you. We are eager to work with you.

Chairman STARK. Let me just restate that a different way because this is rather technical. It is my understanding that there does not now exist a method for prospective risk adjustment that gets much closer, say, than 20 percent of the way there. Do any of you feel differently about that?

Ms. LEHNHARD. About 20, 30 percent.

Ms. IGNAGNI. That is correct.

Chairman STARK. Now, do any of you have a secret program that you are about to spring on us that tells us that you are going to get us to 80 or 90 percent?

Ms. IGNAGNI. No.

Chairman STARK. So if we are counting on risk adjustment for any serious cost adjusting, we are a little ahead of ourselves, is that a fair statement?

Ms. IGNAGNI. This is where you may, Mr. Chairman, decide to proceed by trying alliances in the small group market to develop a track record, a body of experience, and then make some judgment from which we can generalize.

Chairman STARK. I appreciate your suggestion, but I just want to deal with that because it does become very key to making some of these numbers come together, and I don't mean to prejudice anybody's program, it is in several, and I am unable to, in all seriousness, nail that down either in literature searches or in talking to the actuaries yesterday.

There is not a very high level of confidence that we know enough right now to make that work. I just wanted to also finish up. I do hear about the bureaucracy a lot, and I am just going to suggest that our bureaucracy on Medicare is about one for every 10,000 beneficiaries, and I am going to submit that there is not an insurance company in the country, if not the world, that comes close to Medicare's efficiency. And while the bureaucracy, I can make no empirical statements about the quality of the bureaucracy or the results, but I just think it is an incorrect statement. Everybody talks about this big Federal bureaucracy.

It is a 35, possibly 4,000, couple hundred for Medicaid, but we really don't run Medicaid. Am I seriously misstating that?

Mr. English, you are not near one. You have a different sort of problem in that we hire out, we privatize our routine clerical work,

mostly to Blue Cross, so if anybody screws up it is Blue Cross, not us. As a matter of fact, that is where most of the complaints are that Mrs. Johnson talks about, the intermediaries louse it up, and make mistakes.

It is a thankless, routine nickel-and-dime business for the most part, but the fact that when people think of bureaucracy, they think of government employees over here on 3d and C Streets. We don't have many, and I would submit that we don't have as many, "bureaucrats" at the policy level and the administrative level that Blue Cross of California has for 20 million people in California.

I know you don't serve them all, but, yes, you do, and is there anybody who feels that they are much better off than we are in numbers?

Mr. ENGLISH. I think the administration of Medicare, because much of it is contracted to the private sector on a competitive basis and we compete for that business, has that efficiency going for it. It also has the fact that there is indeed a standard benefit plan which we would advocate.

Chairman STARK. No question.

Mr. ENGLISH. The problem I have is when the government tries—

Chairman STARK. You want a board of directors, that is all.

Mr. ENGLISH. When the government tries to set a centrally-planned budget and tries to enforce price controls, it will find it necessary to evoke enormous amounts of bureaucracy.

Chairman STARK. But we do that in Medicare now. We set the prices.

Actually, I am going to tell you how well Mr. Todd's group have done with us. They have done astoundingly well—that is the subject of my next introduction—with a private-public partnership.

Mr. ENGLISH. There is nothing in my experience that would lead me to conclude that if we move to a single-payer system regulated entirely by the government that there will be less bureaucracy.

Ms. IGNAGNI. Mr. Chairman, I would answer your question in a slightly different way. If you raise the issue of whether Medicare should be the standard, I think then we really need to examine it. Medicare is not what many of us would call state of the art in terms of responding to consumers' interests and demands. The quality assurance mechanisms, the data, the feedback.

Chairman STARK. We put a lot more people away than the insurance commissioners in the States. We have a far better record of convictions and prosecutions.

The private insurance companies would love to have us tighten the laws and be able to do as well. You know not of what you speak.

Ms. IGNAGNI. I think, sir, that you perhaps or perhaps I haven't been as clear in my point as I would like. It is the internal quality assurance mechanisms in some of the plans that we represent versus what is not yet happening in Medicare that I think all of us would like to incorporate into the Medicare model.

That will, if we move in that direction, by design raise administrative costs, and that shouldn't be viewed as a bad thing necessarily.

Chairman STARK. OK. Thank you all.

If there are no further inquiries on the part of the members, I would thank the panel very much. I wish you would have been more gracious in accepting the challenge to compete with Medicare, but we will try that another time.

Our next panel consists of Dick Davidson, the president of the American Hospital Association; Dr. James Todd, the executive vice president of the American Medical Association; and the American Nurses Association represented by Gwendolyn Johnson, who is a member of the board of directors.

I don't know whether anybody else has these numbers yet, but we have all heard a lot of contention about the reimbursement of physicians under Medicare, something that Dr. Todd, opposed vigorously but graciously worked with us to make it work after we prevailed, but the answer is that in the first half of this year, as probably you all know, we set targets.

I hate to even suggest global budgets, but we set targets. We set rates as a result of that, but that is about all we do, and we hope that the docs will meet the target. If they don't, we say we will adjust the target.

Well, they did. The nonsurgical services, that is other than physicians, came in about 6 percent under their target. The surgeons must have all gone on vacation, they came in near 15 percent under their target.

Under the rules, this entitles them to a bonus, as it were. Now, this is only the first half of the year, and I am advised that this could change because of the slowness in billing and the rest, but I say it to suggest that there is indeed a structure by which we can bargain with providers and establish rates and maybe accomplish some cost savings or some reduction in the rate of inflation which is really all we are talking about here.

We do this with the hospitals. I know that last year the rate of increase in hospital reimbursement was about half of what it was in Medicare versus the private reimbursement. Again, some of this may very well have been shifted to other providers, either intentionally or unintentionally, but those providers who participated are to be congratulated and encouraged to keep it up.

We on our side will try to do our part by making adjustments where they seem to be needed and there are a lot, I might add, so I would like to start with that introduction to all of you.

The nurses are not yet generally reimbursed by fee-for-service, but they are trying, and so that—

Mr. CARDIN. Mr. Chairman, may I ask you to yield?

Chairman STARK. I would be happy to.

Mr. CARDIN. You gave me a perfect introduction. Maryland, with our system, was one-half the national average for its hospital cost increase this year, so we are even doing better as far as keeping the costs down, in large measure due to the services we had in Maryland of Mr. Davidson. So I can't let this opportunity pass without welcoming Dick to the committee.

This committee has heard more than they want to about the Maryland hospital rate reimbursement system. I know the chairman is a little tired of that being raised.

Chairman STARK. Oh, no, I remind Mr. Davidson of it all the time. He tries to ignore it, but I am glad you are reminding him of his roots because it is very important.

Mr. CARDIN. I just want to thank Mr. Davidson for what he did in Maryland and congratulate him for his leadership at the national level with the Hospital Association.

Chairman STARK. With that, we will let him lead off. Welcome to the committee. Go ahead.

STATEMENT OF DICK DAVIDSON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. DAVIDSON. Thank you, Mr. Chairman, and Mr. Cardin.

I am Dick Davidson, president of the American Hospital Association. We are the voluntary alliance of more than 5,000 hospitals and health care institutions across America. We represent virtually all kinds, private, not for profit, religious, governmental, Veterans Administration hospitals, you name them. They are a part of our umbrella organization; so when we speak to you today, we speak on behalf of a diverse group of hospitals throughout America who have strong commitments to moving toward reform.

And we at the outset want to offer praise to the President and the First Lady for having set the tone for the consideration of reform. And I know, Mr. Chairman, as an advocate of reform for some time, you have got to be excited about the opportunity that this presents this committee and the Congress to really consider changing things to make them better than they are today, and it seems to me that is what we all ought to be committed to.

We will have differences of opinion, but we are going to find some middle ground, and we have got to be reminded that our whole initiative is to better serve the American public. I would like to share with you some ideas about the Clinton proposal, and as you can guess, there are a lot of things in it that we like, and there are a lot of things in it that we have some concerns about. We will come back to the details.

First, the President's plan has a lot of common ground with what the hospitals see as a vision for the future. We have called for improving the health of people in our communities.

We have called for universal access to health insurance. We have called for a more integrated health delivery system. We have called for economic discipline in the system—to get control of growth—that makes sense; and we have called for greater measures of public accountability as well as calling for malpractice reform and anti-trust guidance.

Second, our two highest priorities, as we see them, are first, that we must have universal access in order to really achieve the objectives of honest-to-goodness reform, to do better for the American public. We see that as a moral imperative; and without that, you can't get there from here. I want to say that right at the outset.

Our second priority is that the focus needs to be on changing the delivery system, as you have heard a lot of talk about today. The one that we have today is broken, it is fragmented, disconnected, and it really doesn't serve us well. We can do a lot better.

Finally, as with probably any comprehensive health reform plan you can guess that we see some problems and would like to share

some observations about some of the bumps in the road that we foresee.

But let me accentuate the positive first—how the President's plan fits our vision. We stand squarely behind the President's insistence on achieving universal access to insurance through the workplace. We think it is the only practical way to get there, and we will have a lot of debate along those lines, but we think it is the only way to achieve the objective.

The President's plan also begins to create a new environment for health care delivery for hospitals and doctors and other providers, and we think that is essential, and we have strong feelings about those incentives. The accountable health plans that the President is calling for are close kin to our proposed community care networks.

We would like them to be a little bit closer, and we think we can build on their proposal so that all of us in health care can concentrate on what it is that we do best; and what we do best, and we haven't really been tested, is to help keep people healthy and to take care of them when they are sick, community by community, across the Nation.

Now, the problems and our proposed solutions. First, Medicare spending growth is arbitrarily capped so that \$124 billion is squeezed out by the year 2000. These changes are not intended to fix what is wrong with the Medicare program.

These changes in payments to hospitals and doctors are made solely for the purpose of financing additional benefits, and of course we are for expansion of additional benefits, but not at the expense of reduced payment to hospitals who are expected to treat the elderly. This, coupled with the fact that services for the Medicare population in the President's plan continue to be paid for on a per admission or per visit basis, amounts in our opinion to business as usual.

Medicare's payment system is broken. It is full of incentives for volume growth, which contributes to rising costs, and this is what we have got to change in the years ahead in our opinion. Also, the overall plan reduces the deficit by \$91 billion.

We say take those dollars to expand benefits and use those savings to avoid future arbitrary cuts, and for a truly reformed system, include the Medicare population. We don't think you can leave Medicare out.

About one-third of the patients that we treat, and think about that in rural communities, are senior citizens. We can't reform delivery if, in fact, we have two kinds of payment mechanisms treating two classes of patients differently, so we have got to have Medicare in.

In addition to the Medicare spending cap is the effort to cap spending on the private side.

We agree on the need to slow health spending growth. There is no debate about that, but by establishing a rigid formula to slow growth, the Clinton plan puts the system on what we would call cruise control, kind of takes its hands off the steering wheel and hopes for the best. Our view, instead, is that any attempt to limit spending must include a process to match personal health needs

with available resources in an open and public way where there is honest and public debate about how we allocate these things.

In our view, that is the job of the proposed independent commission. That is the place to begin to have that debate with the support from the Congress in the debate. We don't think you need a system of fixed formulas. It won't work, and we are unalterably opposed to those kinds of governmental price controls. In our view, health care costs can only be controlled if we change the way we operate at the community level.

The Clinton plan does call for a capitated payment arrangement that will in essence bring about cooperation and collaboration at the community level and keep people healthy, and that is the direction that we ought to go. With regard to collaboration, we think that some of the areas of the President's accountable health plans need to be looked at very carefully.

We don't want them to become fly-by-night insurance mechanisms run by people in tall buildings in New York with computers and discount contracts. We think that they have got to be plans that are locally controlled and locally coordinated and are accountable to local communities.

In closing, Mr. Chairman, these are the key issues for America's hospitals. We have a lot of other ideas on the President's plan.

We will stop at this point and just say to you, we pledge our support in being constructive players for reform. We don't believe that we can maintain the status quo, not only because we don't want to.

We think there is a better place to get to and we are calling for more change in the behavior of hospitals and doctors than perhaps any other organization in the United States. We feel very proud of that, so we pledge to you our support.

[The prepared statement follows:]

American Hospital Association



Capitol Place, Building #3
50 F Street, N.W.
Suite 1100
Washington, D.C. 20001
Telephone 202.638-1100
FAX NO 202.626-2345

Statement
of the
American Hospital Association
before the
Subcommittee on Health
of the
Committee on Ways and Means
United States House of Representatives
on
President Clinton's Health Care Reform Proposal

October 7, 1993

Good morning. I am Dick Davidson, President of the American Hospital Association, representing 5,000 hospitals and health care organizations across America. It is a pleasure to be here this morning in the cause of moving health care reform forward. Members of this subcommittee have been true pioneers in the effort to extend and improve health coverage for the nation, and I know you share the American Hospital Association's excitement about the real opportunity for achieving that goal that the current environment provides us.

AHA salutes President Clinton and the First Lady for their significant work in nurturing the current reform climate. America's hospitals, through AHA, have worked for more than two years to shape our own blueprint for health care reform: we are very pleased that the President's plan shares many of our building blocks. In a nutshell, AHA's reform objectives include:

1. Universal access in a reasonable time period financed in a pluralistic manner;
2. Redeveloping health care delivery into an integrated and coordinated system able to address the needs of the population;
3. Economic discipline based on clear incentives rather than micromanagement;
4. Balancing promised benefits with adequate financing;
5. Public accountability for the clinical effectiveness and economic efficiency of health plans;
6. Antitrust and malpractice reform.

Areas of Agreement With Clinton Plan

You will notice that "universal access" is at the top of the list. We share the President's belief that any reform plan must move us as quickly as possible to health coverage for all. This is a non-negotiable item for us, not only because it is the morally right thing to do, but also because without universal coverage health care reform simply doesn't work -- without it, you will still have a system with providers continuing to shift costs from the uninsured to the privately insured, undermining our goal of moderating rising health costs.

The other basic building block we share with the Clinton proposal is its boldness in calling for a fundamentally restructured health care delivery system. In the Clinton proposal, health plans would offer a guaranteed national benefit package to consumers, without regard to pre-existing conditions. The plans would receive a fixed, per-person annual payment, providing the financial resources for preventive care that our current system so sorely lacks.

The Clinton proposal's "health plans" provide the structure to accommodate AHA's own approach to restructuring the delivery system through community care networks[™] -- cooperating groups of local providers paid on a capitated, or per-person, basis. This approach provides the economic incentives for providers to work together, eliminating expensive duplication of services and technology, and for establishing a seamless system of care that works better for patients.

We also like the fact that the Clinton proposal establishes a framework for a national independent commission that would interpret and update the guaranteed national benefit package to be offered to consumers. And, we endorse the proposal's movement toward more clearly spelling out antitrust guidelines. The current antitrust climate is murky. Hospitals that want to merge or share technology are sometimes discouraged from doing so out of fear of running afoul of the Justice Department and regulators. This chilling effect undermines our shared goal of achieving greater efficiency in health care delivery.

Suggested Improvements in the Clinton Plan

While we have more agreement than disagreement with the Clinton proposal -- more common ground than battleground -- we would like to share with you our areas of significant concern, and offer our view of how these areas can be improved.

Medicare

First, under the Clinton proposal Medicare spending growth is capped so that \$124 billion is squeezed out of the program by the year 2000. These changes are not intended to fix what's wrong with the Medicare program. They will fund prescription drug and long-term care benefits for the elderly. We are supportive of these benefits, but we can't support underpaying hospitals in order to finance them.

The solution? The Clinton plan calls for using reform savings and taxes to reduce the deficit by \$91 billion. We believe those savings should be left in the health care reform effort where they can reduce the need for arbitrary cuts. First of all, providing universal access to health coverage is going to increase health spending. This is not the time to be bleeding resources from the system. Second, the process of reconfiguring hospitals and other provider services also takes financial resources. We know from experience that laying out a solid plan for merging services between two hospitals, or between a hospital and physician group, can take a year or more. Hospitals must have the resources that allow them to do this -- resources that could be freed up through the greater efficiencies and lower administrative costs that are the bounty of reform. But our fear is that a too-constrained financial environment at the outset could prevent reform from getting off the ground.

The infrastructure investments we all endorse in order to reduce administrative costs -- electronic billing, computerized patient records, new information systems -- also require front-end dollars before they can be put in place. Our ability to get beyond the traditional hospital acute care role that will be necessary under reform is also jeopardized by excessive spending reductions. For example, consumer education, wellness, and

outreach programs -- not funded by the current system -- are among the most vulnerable programs when finances are squeezed.

Global Spending Caps

A similar disconnect of actual needs from resources happens on the private side in the Clinton proposal, where spending growth is capped by tying it to the Consumer Price Index (CPI). But the CPI has no real link to the actual costs of providing care; health care has its own set of input costs that aren't reflected in the CPI -- labor costs that are driven up by health care personnel shortages and the steeply rising cost of new medical technology, for example.

We agree on the need to slow health spending growth. But to try to do it through a rigid formula amounts to putting the system on cruise control, taking one's hands off the steering wheel, and hoping for the best. That is not a responsible way to navigate the uncharted territory of health reform. Why? Because it doesn't allow us to adjust course to accommodate unforeseen circumstances. The slowness of the economy in coming out of the recession, previously unknown crises such as the AIDS epidemic -- all caution that we keep our hands firmly on the steering wheel. And the way we do that is to match health needs with available resources in an on-going, open and public way. In our view, that should be the job of the independent national commission.

Structure of Health Plans

We also have concerns about the structure of the Clinton health plans. While they have shared characteristics with our vision of integrating care through community care networks, they are by no means identical. The health plans must have a better-defined role set out at the national level, and more accountability built in at the local level. We have real concerns that as currently defined they could harbor fly-by-night insurance schemes. The way to address these concerns is to make sure health plans are under local governance, are targeted toward meeting local needs, and have a local accountability mechanism.

Conclusion

There are many other aspects of the Clinton plan -- some of which require further clarification -- that we are currently reviewing. These include: the size and role of the alliances; the process for seeking state waivers; payments for the training of physicians and other allied health professionals; the treatment of illegal aliens; and the role of providers in underserved areas, both rural and inner city. We will continue to study these issues and look forward to working with you to find the best way to include them in comprehensive reform.

So yes, there is work to be done in examining these issues and other areas of concern. We need to work together to identify options and compromises. But it's not an impossible job. We have been given a strong start by the President and the First Lady in putting forth a serious reform initiative. Much work has already been done in Congress as well, including efforts by this subcommittee. And a spirit of bi-partisanship is emerging.

For those of us who see a broken health care system and want to fix it, it's a truly exciting time -- even an historic time -- for health policymakers and providers. We sense a rare opportunity, an opportunity that may not come again for a long time, to reshape our health care system to make it work better for all of us.

Hospitals pledge to play a constructive role in that process -- to work hard to support reform elements we believe build the right foundation, and to find agreement in those areas we now feel are not solidly grounded. As the American Hospital

Association serves in that role, we don't see ourselves as advocates for the President's plan, the Conservative Democratic plan, the Senate Republican plan, for business or for labor. We see ourselves as advocates for the workable, the truly better -- in short, for good public policy.

Legislation that captures these qualities is likely to be drawn from positions all along the political spectrum. As politicians skilled in the art of compromise, I know you recognize that truth as well. The American Hospital Association looks forward to working with you to reach our shared goal of better health care for all Americans.

Chairman STARK. Thank you.
Dr. Todd.

**STATEMENT OF JAMES S. TODD, M.D., EXECUTIVE VICE
PRESIDENT, AMERICAN MEDICAL ASSOCIATION**

Dr. TODD. Thank you, Mr. Chairman, and members of the committee.

I am Jim Todd, the executive vice president of the American Medical Association, and we are pleased to be here today to provide our views on the President's health system reform plan.

We applaud the President, as well as the First Lady, for taking the first necessary steps in bringing to an end the difficulties that too many of our patients have in finding affordable adequate health care coverage. The basic principles of the President's plan mirror what the AMA has been calling for in its own plan, health access America, for the last 4 years.

Both plans seek to build on what already works well in health care; both would make certain that the health care system works fairly for all Americans, and we also understand the need to produce a system that is disciplined and can provide a measure of quality upon which our patients can rely.

Our plans also agree on the need for universal coverage, a national package of health benefits emphasizing preventive care, a requirement that all employers share in the responsibility of providing coverage that most employees in America have long enjoyed while at the same time providing mechanisms to deal with the potential for dislocation among small employers and their employees.

Insurance reforms that will require insurers to insure risk, not avoid it, a competitive environment where health care costs at all levels will have to be justified, and pluralism as a means of guaranteeing health care quality and access. We are pleased that in the various discussions we have had with the administration, as it has crafted this proposal, that many of the suggestions that we offered were accepted.

In many other respects, however, we do not see the necessary level of physician participation on behalf of their patients in some of the most crucial aspects of the President's plan that we have discussed with them. But we understand that modification is ongoing and we are encouraged that the President has signaled the willingness to negotiate specifics of the plan.

Yet right now physicians simply have too many questions about how that plan is going to be implemented, about why the plan's effort to cut waste in spending does not go far enough in limiting liability costs through caps on noneconomic damages and meaningful limits on attorneys' fees; about why physicians will not be given adequate exemptions from current antitrust restraints to allow them to protect their patients' interest in a health care market that will be dominated by large managed care entities under this plan; about why strict spending controls are called for when they have never been shown to work anywhere, with a National Health Board designed basically to regulate the system when better, more participatory models for providing guidance to the health care system are available; about health alliances that could add yet another level of regulatory authority to the system when all that is

needed is an impartial entity that helps organize the way insurers and small employers come together in the marketplace; about the intent to nationalize medical education by essentially telling students what careers they may pursue, something done nowhere else in any field in this Nation; and about why a whole new bureaucracy of quality oversight will be better than that now existing in the private sector.

Before physicians can say whether they oppose or support the President's plan, they need far more detailed answers to these questions. Other health system reform plans have been and will continue to be offered from both sides of the aisle.

None are perfect nor should we expect them to be at this juncture, but on balance the President deserves our congratulations for his unprecedented leadership in making at long last meaningful comprehensive health system reform a real possibility.

We also congratulate this committee and its chair not only for past leadership but also for quickly beginning the task of examining and shaping health system reform. There is still much work to do, and at the end of this long process when all is said and done, physicians will judge the acceptability of any health system reform plan on only two criteria: will patients have the freedom to obtain care from the provider in the facility of their choice and can physicians provide necessary effective and efficient care without undue restrictions on their clinical judgment?

Our patients deserve positive answers to these questions, and the American Medical Association promises to work with the administration, the Congress, and our patients to see that positive answers will be achieved.

Thank you.

[The prepared statement and attachment follow:]

STATEMENT
of the
AMERICAN MEDICAL ASSOCIATION
to the
Committee on Ways and Means
Subcommittee on Health
U.S. House of Representatives
Physicians' View of the President's Health Plan
Presented by: James S. Todd, MD
October 7, 1993

Mr. Chair and Members of the Committee:

My name is James S. Todd, MD, Executive Vice President of the American Medical Association (AMA). Accompanying me is Ross N. Rubin, JD, of the AMA's Division of Federal Legislation.

On behalf of the AMA's 300,000 member physicians, I am pleased and honored to be able to share with you what I believe many individual physicians would say about the President's proposal for health system reform if they had this opportunity to be here and talk with you today.

The President's proposal is long awaited. Physicians know the limitations of the current system. They see the difficulties far too many of Americans have finding affordable, adequate health care coverage. For the past four years, the AMA has been telling whomever would listen about the need for comprehensive reform and a way to achieve meaningful change through our own proposal, **Health Access America**. Before that, we helped organize an effort of leaders

among physicians, a wide range of health care providers, academia, and both federal and state government to define the difficulties and solutions needed to address problems in the health care system -- called **Health Agenda for the American People** -- well before the problems of the health care system captured the public's attention as they have in the last several years.

We have long understood that problems with America's health care system had to be addressed, that the status quo was no longer sufficient. We applaud President Clinton for his resolve in addressing these problems, in taking the first necessary step to end the status quo. Likewise, we applaud the First Lady for her leadership in the difficult process of framing the President's proposal. It is encouraging to physicians that the President has signalled a willingness to negotiate details of the plan as long as such negotiation does not undermine the basic principles of reform. We look forward to such negotiations as the package proceeds through the Congress.

For these reasons alone, I can confidently say that the Administration, the Congress, the medical profession and others can move forward into a new era of health system reform.

Building Fairness into What Works

Our confidence that we can accomplish our joint goals is fueled by how much there is in President Clinton's proposal that reflects our own plan for health system reform. Most importantly, we share President Clinton's intended goal of building on what works well in the system now, not replacing it or tearing it down. We also recognize that a strong theme in the President's proposal is enforcing fairness on a system that, for all the world-leading wonders in medical care it makes readily available to most Americans, does not fairly ensure that all Americans have access to that same level of care.

Every American should have coverage so that the system is available to every American. and the rules of the system should work the same for everyone. President Clinton's proposal would make a great leap in ensuring that they will -- by making sure that all employers share in the responsibility of offering health care coverage that most employees in America have long enjoyed; by defining at the national level a package of health care benefits including preventive care that will be available to all Americans; by requiring health insurers to insure risk, not avoid or limit it; by reconstructing federal tax incentives so that the self-employed are treated the same as large corporations, and ending federal tax dollar underwriting of health care benefits richer than the nationally defined benefit package; and by establishing reasonable cost-sharing requirements that will encourage individuals to assume a level of responsibility for the health care choices they make. We are also encouraged that the plan recognizes the need for liability reform to be part of health system reform.

These changes alone would bring about a resolution of many of the difficulties our patients now experience in the health care system. Even more is needed, though. Unfortunately, many of the directions taken in the President's proposal beyond these basic principles create in physicians serious reservations about the effect the proposal, if enacted as it stands today, would have on the ability of physicians to provide quality health care to their patients.

One Measure: The Physician-Patient Relationship

There is only one measure by which physicians will judge this proposal -- how will it affect the ability of a physician and his or her patient together to make whatever decisions are necessary about the patient's medical needs. When a physician sits in an examining room with a patient facing a difficult, often life-threatening moment of decision, the physician needs to

know, without doubt, that a decision can be made solely in the best interests of that patient's health and well-being, nothing else. As the President's proposal stands now, far too much could come between the physician and patient at that moment of truth, making it difficult to make the best possible decisions on behalf of patients.

The combination of arbitrary global budgets, premium caps and the need to save dollars by plans could necessitate many of the same intrusive controls and second guessing of physician decisions that exist in many of today's tightly controlled insurance plans. Such interference is, has been, and continues to be inappropriate. It is inappropriate now when insurance companies arbitrarily second-guess physicians' clinical decisions in utilization review or force physicians to step out of the examining room to seek preauthorization for necessary care. It is inappropriate when the threat of liability action forces physicians to order tests that would not be necessary in a less hostile environment.

Under a new health care system, we must avoid interference that results from decisions about the availability and quality of health care made from a bureaucratic, centralized place, distant from the patient's bedside, and disconnected from the needs of a physician's individual patient. There are many positive aspects of the President's plan that could and should be carried out with little government involvement, however new levels of bureaucracy are envisioned at the federal, state, and corporate levels. Physicians wonder what role will be left for them in the new system.

Federal Interference

At the federal level, a national health board of seven individuals would have sole responsibility for establishing, administering, and disciplining the system proposed by the

President. One of its key responsibilities would be to enforce global budgets on health care spending. If such budgets were truly targets, meant as a flexible guide established with the help of physicians to assist in identifying cost difficulties and specific solutions, reflecting changing demographics and specific health care needs across the population, the AMA could support them. Instead, the "targets" here are strict spending controls based solely on changes in the Consumer Price Index and enforced through the cost of insurance premiums, with potential assessments on providers.

Nowhere in the world, in any kind of system that delivers any service or good to anyone, have such spending controls ever worked. Their implementation does nothing to control the demand for services and often times increases that demand. Such controls result in arbitrary maldistribution of services that often falls far short of meeting consumers' needs. With health care in the United States, the result will be no different. Treatment plans on how to meet individual patient needs now made between a physician and a patient in the physician's examining room could be made instead in Washington, DC. Physicians cannot accept this limitation. We do not believe our patients will either when beneficial care is not promptly available. That is not the kind of reform the American people are expecting.

Physicians have the same kinds of concerns about the control the federal government will be taking over the supply of physicians under the President's proposal. By mandating medical schools to train 50% of their physicians in primary care and allocating medical residency slots through new national and regional graduate medical education councils, the federal government will essentially nationalize medical education in this country. While there is a need for more primary care physicians throughout the nation, the incentives to practice primary care included

in the President's plan, along with changes in the health care marketplace that are already happening, may well be enough to encourage and enable medical students to pursue primary care. The AMA has advocated for these same incentives for a long time. They should finally be given an opportunity to work.

State Interference

At the state level, health alliances, as proposed in the President's plan, will only add to this bureaucratization of the health care system, providing another layer of decision-making which could undermine the physician-patient relationship. The AMA has watched with interest the development of the concept of health alliances in the managed competition proposals that have come before Congress. In a pure managed competition approach, health alliances -- or insurance purchasing cooperatives -- would act simply as unbiased conduits between health insurance plans and consumers, acting to organize the market under rules that apply equally to all. There is a need for such a role to be played to help small businesses organize their purchasing power in the insurance market. Such a system -- the Federal Employee Health Benefit Plan (FEHBP) -- provides health benefits to federal workers, members of Congress, and their dependents. With little bureaucracy, FEHBP empowers individuals to make rational insurance purchasing decisions based on their needs and desires. The American people deserve no less.

President Clinton's proposal for health alliances goes beyond this basic need, however, giving alliances what will amount to regulatory command and control authority, in concert with the national board, to enforce premium prices on insurance plans and exclude plans with higher premiums. Authority also is given to alliances to determine what kinds of health plans would be allowed to compete by limiting the number of fee-for-service plans under an alliance. This

is not competition. We recognize the need to manage competition fairly, but this limitation is not fair and is not going to promote competition, which is the only way that cost-effectiveness and quality health care can be guaranteed. An open fee-for-service plan should be available in every area of the country.

The proposal for health alliances is also problematic in that it requires all employers with up to 5000 employees to purchase coverage through them. Such a high threshold will give alliances far too much market power in a state or region, choking off pluralism and competition in a market. It is truly small employers, those with less than 500 employees, that need government help in pooling their resources to buy insurance, not employers with thousands of employees. Government involvement should be limited to where there is a need, allowing competition to work where it is able. Allowing medium sized employers to maintain their own plans will provide an appropriate counterbalance to the power of the alliance and will provide freedom for an expanded number of plans in any particular geographic area.

Corporate Interference

Finally, physicians see the erosion of their professional decision-making role and their ability to represent the best interests of their patients in the overwhelming preference the plan gives to what will no doubt become large corporate managed health care entities. The AMA does not oppose managed care. We understand the current economic pressures that are already pushing more and more physicians into managed care arrangements. That is competition, for now. A health care reform plan should not, however, codify that marketplace phenomenon. If fee-for-service is truly noncompetitive, our patients should make that decision, not the federal government. Government action should at least be neutral, or, where there is a dominance in a

market. should help balance the marketplace to encourage competition.

Instead, we see an overly narrow definition of fee-for-service under a proposal labeled fee-for-service that eliminates many of the elements of fee-for-service. Rather than giving physicians and patients the ability to choose how and where medical care is delivered, and how much the service should cost, the government will impose a price on services that all physicians choosing to practice outside large managed care entities will have to accept. It is doubtful whether many physicians will be able to make this choice outside of already underserved areas of the country where managed care corporations will not find it cost-effective to go. In a short time, managed care will have no competition in the marketplace. A physician will have little choice if she or he cannot agree to managed care decisions that limit her or his ability to meet patient's medical needs. Such a situation is unacceptable to physicians. The fee-for service option, as proposed by the President combined with the global budget would limit patient freedom of choice to only an IPA/HMO type of fee-for service plan.

True fee-for-service, without arbitrary constraints, should be given an opportunity to fully compete in a new health system. Instead of price controls, a reimbursement system based on the RBRVS could be created, giving patients an opportunity to compare prices based on physicians' choices of conversion factors they individually want to apply.

Also needed are greatly expanded protections from anti-trust constraints for physicians to ban together and organize networks to compete with the accumulation of health care market power in large corporate entities. Physician organizations like the AMA should be allowed to represent physicians. Current restraints on such activities are already no longer valid where individual physicians have little choice but to accept arrangements offered to them.

Physicians also must be given the opportunity to compete for patients in such markets, by requiring dominant managed care entities to allow physicians who meet credential requirements to provide care under a managed care arrangement. Large corporate entities should not be allowed to freeze otherwise qualified physicians out of providing needed care to their patients if those patients want to choose that physician.

Financing

Fueling physicians' concern over the President's proposal is the light brush that has been given to financing the plan. The key revenue source offered is a continued federal cutback in Medicare and Medicaid funding. Not only is this unacceptable to physicians and their patients who rely on these already underfunded programs, it is doubtful that this can be a reliable revenue source to fund the expansion of health care access hoped for in the proposal. An increased "sin" tax on tobacco has been proposed by the President, which the AMA would support. We would also support increased taxes on alcohol as well as increased cost savings that will come with administrative savings envisioned in the plan.

With some reservations, the administrative cost savings offered in the plan are laudable and necessary. But given the bureaucratization of health care at the federal, state, and corporate level provided in the plan, we see, in fact, greater administrative costs, not less. For example, the National Board will have numerous sub boards and commissions, such as in quality, benefits, graduate medical education, that will all need to develop complex rules and regulations. A system that adds levels of management, not reduces them, can only be more expensive. The absurd duplication of oversight over the physician-patient relationship physicians now experience under insurance company control will not lessen under a system dominated by large corporate health

care entities; more oversight is only added through the new state and federal superstructure of control. We simply do not see sufficient administrative cost savings in the President's proposal.

And where there are unnecessary costs in the system in the high cost of liability both in litigation costs and defensive medicine, the President's proposal takes too little action. To ensure such high costs do not continue under a new system, initiatives similar to those taken by California under its MICRA liability reform law should be enacted. A \$250,000 limit on noneconomic damages must be established if true cost savings are to be achieved, and limits on attorneys' fees significantly below the 33 1/3 percent limit proposed by the plan are needed. That is no limit at all, since this is the typical share of awards taken from their clients now.

Physicians need to know from where the actual financing of the President's proposal will come.

Conclusion

The President and the First Lady should receive full credit for advancing the health reform issues and ensuring that health system reform has finally begun. Now, Congress has an unprecedented opportunity to enact legislation that will change forever the way health care is delivered in this nation. It is our intent to help ensure that change is for the positive, so that all Americans can receive the high quality, personal medical care that most Americans now receive from their physicians. That is our goal.

My comments today are general. It is my intent to provide an overview of our more basic concerns as the President's proposal applies to physicians' ability to continue to serve in their professional role of providing medical care to their patients, without constraint, a matter on which physicians have serious reservations. (A detailed response to the President's plan is attached.)

As the members of this Committee well know, many hearings can and will be held on these and many more specific issues over the next several months. I hope and trust that the AMA will have the opportunity to make more specific comments when the time is appropriate.

AMA's Analysis of the Clinton Plan

The President's Program	AMA's Response
<p>Coverage</p> <p>All US citizens/legal residents must enroll in health insurance plans. Plans may be purchased through a state/regional health alliance. A large employer (more than 5000 employees) may provide coverage through its own alliance. Health security card entitles each to nationally defined comprehensive benefit package. Government employees, Medicaid beneficiaries, and retirees under age 65 also purchase through alliances. Medicare, military health care, VA, and Indian Health Service continue.</p>	<p>Purchasing cooperatives can be useful in helping small businesses pool their purchasing power to buy insurance. Large employers should remain outside of alliances to create true competition. As envisioned here, though, alliances have far too much market influence and must serve a regulatory role under the control of the national health board. For alliances to work, large employers must be defined at more than 500 employees, not 5000. It is truly small employers, not ones with thousands of employees, who now have problems buying insurance and could use alliances. By including large employers, alliances will monopolize markets, thereby reducing competition and consumer control of health care decisions. Also, the alliances are far too much under the control of the national health board to be effective, especially because of the budget caps they must enforce. Rather than helping improve the insurance market, alliances will serve as regulators, thereby bureaucratizing the health care system even more than it is now.</p>
<p>Employer Requirement</p> <p>All employers must pay 80% of weighted-avg plan premium for all employees, with pro-rata contribution for part-time employees under 30 hrs a week. But employer contribution is capped at 7.9% of payroll. Small employers (less than 50 employees) are capped between 3.5% and 6.5%, depending on employee avg annual wages. Corporate alliances: self-insured large employers (5,000+) and equally large union plans may self-fund, contract with health plan, or arrange coverage through alliance; but must generally meet same requirements as insured plans.</p>	<p>The AMA believes that the best way to achieve meaningful health reform is to build on the existing employer-based health insurance system. The inequities in the current system should be addressed without sacrificing the health care quality and access that most Americans enjoy. This goal can be achieved through an employer requirement with appropriate protections for small businesses. Likewise, it is critical for employers to contribute the same percentage of premium to whichever plan its employees choose, otherwise the system is biased toward managed care. The percent of payroll cap is too low for large business, discouraging them from establishing their own plans, therefore increasing monopsony buying power of the alliances.</p>
<p>Employee/Individual Requirement</p> <p>Employees pay 20% of weighted avg-cost alliance health plan, depending on its cost. Self-employed and unemployed pay 100%, but anyone below 150% of poverty receives federal premium assistance from alliance. Undocumented aliens not eligible, but federal aid to institutions for their care continues. States must address migrant worker issues.</p>	<p>The federal government must increase, not reduce its funding and leadership in addressing undocumented individuals and migrant workers. Problems associated with providing them care go far beyond states' resources. Assistance should be provided for individuals and families with incomes under 200% of the poverty rate.</p>
<p>Nationally Defined Benefit Package</p> <p>Comprehensive medical; clinical preventive services based on periodicity schedule; hospice and home health; 30 days/episode and 60 days/yr inpatient mental health/substance abuse with 30 visits/yr psychotherapy; family planning; pregnancy-related; hospice; outpatient prescription drugs; rehab; DME and prosthetic/orthotic devices; vision/hearing; preventive dental for children; health education.</p>	<p>The preventive benefit package is inadequate and does not appear to use most current data. Other benefits are not inconsistent with AMA's own recommendations for a standard benefit package. But much more detail is needed. Any national health board updating of this package should be subject to Congressional approval. Coverage for mental health/substance abuse should mirror medical care.</p>

The President's Program	AMA's Response
<p>Cost Sharing</p> <p>Health plans may offer 1 of 3 options:</p> <ul style="list-style-type: none"> • Low cost sharing -- no deductible, \$10 copay for outpatient services but none for inpatient, 40% coinsurance point-of-service option, \$1500 individual/\$3000 family out-of-pocket max, \$5 copay for prescription • High cost sharing -- none for preventive; \$200/\$400 deductible, 20% coinsurance, and same out-of-pocket max for inpatient/outpatient; \$250/yr deductible, 20% coinsurance, and same out-of-pocket max for drugs • Combination -- low cost sharing if preferred providers used and higher cost sharing with 20% coinsurance for out-of-network providers; same out-of-pocket max. 	<p>Under low cost sharing, 40% coinsurance for a point-of-service option is unacceptable, especially under a plan that will allow managed care plans to dominate the market. To help ensure the quality of managed care, patients must be given a reasonable opportunity to see physicians outside a plan. Further, managed care plans should be required to accept any physician who meets stated credentials and who agrees to provide services under an agreement with the plan and subject to plan capacity. Medical savings accounts (MSA) should be authorized to assist individuals and families in meeting out of pocket expenses including co-insurance and deductibles. Plan should authorize individuals to contract for any health services they want with their own after-tax funds</p>
<p>National Health Board</p> <p>National board oversees the establishment and administration of the new system. President appoints 7 members to staggered 4-yr terms who then are federal employees and may not have health care assets; 1 must represent states. Duties include</p> <ul style="list-style-type: none"> • implementing and enforcing national health spending budget • establishing state plan requirements, monitoring compliance • reviewing alliance plans submitted by states, with enforcement through HHS and Treasury • interpreting/updating benefit package • setting quality management/improvement system • commenting on breakthrough drug prices, but cannot control drug prices. 	<p>The AMA unequivocally opposes a national health spending budget and giving a national board responsibility for implementing and enforcing one. Such centralized decision-making and artificial spending have never worked anywhere and will quickly bring about difficulties in health care access and quality. A truly representative national commission may be able to help in setting goals for the health care system for expanding access, and in setting budget goals that take into account disease and demographic changes and changes in demand. But this proposal creates a new federal bureaucracy with price control authority. Also, it is unacceptable that no place has been reserved on the board for a physician or AMA representative.</p>
<p>State Responsibilities</p> <p>States</p> <ul style="list-style-type: none"> • by 1/1/97, must establish at least 1 alliance and assure all eligible individuals enroll • certify health plans to participate in alliances • ensure the availability of a plan priced at or below weighted-average premium • submit to National Health Board plans to regulate health plans, administer data collection and quality management/improvement • may establish a single-payor health care system complying with benefit package and cost sharing requirements, or a single-payor alliance for part of a state. 	<p>The AMA strongly opposes the establishment of a single-payor health care system, whether on a state or national level as part of national health system reform legislation. No centralized decision-making authority can control costs and ensure adequate access to quality services, especially in health care. When, for good reason, the national plan rejects a single payor system nationally, allowing a state to subject its residents to such an unreasonable approach is contradictory and makes little sense.</p>

The President's Program	AMA's Response
<p>Health Alliances</p> <p>Health alliances are meant to act as conduits between health plans and individual purchasers of health insurance coverage, contracting with health plans to provide the required benefit package and providing a simplified, uniform means for individuals to choose between plans. Alliances</p> <ul style="list-style-type: none"> • must contract with a plan unless its premium exceeds the weighted-avg premium by more than 20%, its quality is poor, or it discriminates. • must use risk-adjustment mechanism to account for enrollment variations across plans • may be a nonprofit corporation or state agency, but nonprofit's board must equally consist of consumers and employers whose selection is determined by the state • must establish provider advisory boards • must enroll all eligible individuals and have annual open enrollment periods • may not bear insurance risk • must publish consumer info on cost, providers, access restrictions, and quality of plans. <p>Alliances must offer at least 1 any-willing-provider fee-for-service plan, but may limit number to 3 through competitive bidding. National board may waive requirement if not viable or insufficient interest. After collective provider negotiations, alliance sets provider fee schedule for each fee-for-service plan, and providers may not balance bill. States may impose prospective budgeting on fee-for-service plans. Corporate alliances must also offer at least 1 fee-for-service plan.</p>	<p>The AMA is adamantly opposed to the plan's restrictions on fee-for-service. True fee-for-service gives individuals the freedom to choose health care services. By establishing a fee schedule and barring physicians and patients willing and able from agreeing to the cost of their medical care, true choice no longer will exist in the US health care system. Physicians and patients will find it difficult to use choice to guard against health care decision-making made at corporate and bureaucratic levels, thus diminishing the ability of physicians to advocate for their patients.</p> <p>If a health alliance acts as an impartial conduit between health plans and purchasers, acting to make it easier for individuals and small businesses to make insurance purchases and encouraging competitiveness between health plans, health alliances can help bring about needed fairness in the health insurance market. If an alliance cannot act fairly, true competitiveness cannot be assured. Alliances should be required to accept all fee-for-service plans offered, instead of limiting the number to 3. True freedom-of-choice for individuals to determine what kind of health care delivery best meets their needs is severely diminished.</p> <p>Plans should be encouraged to recognize the RBRVS for determining physician reimbursement using individual physician selected conversion factors.</p> <p>Plans should authorize individuals to contract for any health services they want with their own after-tax funds.</p>
<p>ERISA</p> <ul style="list-style-type: none"> • Corporate alliances subject to new fiduciary/ enforcement requirements regarding national benefit package, plan info requirements, and uniform data, claims, electronic billing, and grievance procedures. • Self-funded plans must set benefit payment trust fund; beneficiaries receive special protection in bankruptcy if employer fails. • National guaranty fund established. • ERISA preemption of state laws modified to apply only to corporate alliances, allow nondiscriminatory taxes on them, allow state all-payor rate setting, allow states to include corporate alliances to reimburse essential community providers. 	<p>AMA has long supported ERISA reform. The plan proposes to address many of the problems identified by the AMA that have developed under ERISA, including protecting beneficiaries of self-insured plans from unfair coverage decisions and plan insolvency. Such changes have long been needed to ensure that all Americans are treated fairly by those who insure their health benefits, whether an employer or an insurance company.</p> <p>However, ERISA's preemption of state law should not be amended to authorize a state single payor system to apply to large employers or to allow varying reserve requirements from insured plans within the state.</p>

The President's Program	AMA's Response
<p>Health Plans</p> <ul style="list-style-type: none"> • Health plans must accept all eligible individuals, have an open enrollment period, and may not cancel/reduce benefits even for enrollee nonpayment. Pre-existing condition limits and disease-specific exclusions are prohibited. • Each August, alliance negotiates premium rates with each plan and publishes rates. Employer/employee pay community rate. Alliance adjusts payments to plans based on risk, using formula set by national health board. Plans with high risk populations may reinsure. • Plans must provide alliance with extensive info on cost, quality, provider availability, UR, consumer rights, and plan responsibilities. • Plans must provide consumers info on risks, benefits, medical procedure costs, and advance directives. Grievance procedures and alternative dispute resolution required. • State laws protecting against managed care abuses are preempted. • State laws banning the corporate practice of medicine are preempted. • The ability of plans to own facilities or offer medical services is authorized. • Out-of-service-area emergency/urgent care required, paid on alliance's fee-for-service payment schedule. • A plan must have advisory boards of providers selected by providers, which must be consulted frequently and has access to plan information. • Loans are available for community-based plans. 	<p>The insurance reforms offered in the President's plan are important elements of health system reform. Setting premiums based on community rating and eliminating pre-existing condition exclusions have long been urged by the AMA. Health Plans should be required to create a committee of practicing physicians within the plans that is responsible for establishing clinical decision criteria. Exceptions to community rating should not be granted to large firms. Establishing a system of sharing uniform information about plans through the alliances will help consumers make informed insurance purchasing decisions. Nevertheless, provisions that would preempt laws that states have enacted to protect against abuses in managed care need to be eliminated. The President's plan, overall, gives such a strong encouragement to managed care that states need to be allowed to continue their authority to act when abuses occur.</p> <p>The plan should not override state corporate practice of medicine laws in states that currently prohibit such.</p> <p>Further, managed care plans should be required to accept any physician who meets stated credentials and who agrees to provide services under an agreement with the plan and subject to plan capacity.</p>
<p>Global Budgets/Price Controls</p> <p>The plan describes a national health care budget based on the weighted-avg premium for the guaranteed benefit package as a targeted backstop to market action. The target increase in premiums for 1996 is CPI + 1.5, CPI + 1 for 1997, CPI + 0.5 for 1998, and CPI for 1999 and beyond. A national per capita based premium is set by the national board, as is a system to adjust at alliance level for risk factors like age/demographics. Alliances then receive an avg premium from the national board. Plans submit bids to alliances either blind or with knowledge of the target. Alliances then submit their negotiated premiums to national board, which tells the alliance if its avg premiums is acceptable or not. If not, the alliance renegotiates. If the alliance exceeds its target, there is a 2-yr recoupment. Targets may not be adjusted, except by Congress. Corporate alliances use an equivalent target and are terminated if they miss target 2 out of 3 yrs.</p>	<p>The AMA staunchly opposes the setting of any national budget. Any decision-making in health care based mainly on economics and not on patient needs is not in the best interests of patients, and will lead to rationing that cannot address the difficulties and inequities in our current health care system. This issue will be a key area of concern and activity in the coming months as health system reform continues in Congress. The President's plan calls its spending limits "targets." The AMA believes that a participatory process that includes physicians might be useful to establish true goals that can be flexible and are based on patient needs. As written, though, these "targets" are stringent, arbitrary caps on spending. This is fully unacceptable.</p>

The President's Program	AMA's Response
<p>Administrative Simplification</p> <ul style="list-style-type: none"> National board must develop simplified forms. By January 1995, UB92 must be used for institutional services, standard health insurance claim form similar to HCFA 1500 for noninstitutional, HCFA 1500 for dentists, and universal drug claim form for pharmacies. National board must set automated transaction and coding standards. Private payors must adopt electronic data interchange (EDI) standards by 1/1/95; federal programs ASAP after enactment. Providers, including medical groups of over 20, must automate within 6 months of standardization. States may deny payment to plans not using EDI. Medicare simplification: contractors will be consolidated based on function, not area, balance billing for DME eliminated, national data file on Medicare beneficiaries created, and Medigap terminations take place as part of national data file; presumptive waiver of co-insurance with physician's acknowledgement; physicians input in carrier performance; Parts A and B claim processing integrated; attestation requirement eliminated except for hospital medical staff privileges; pre-approval for 10 surgical procedures eliminated; system changes more than once every 120 days prohibited; PROs must focus on patterns, not individual cases. The health security cards all individuals receive is like an automated teller machine card, to be used to access a national uniform health data set established by the national board. Unique identifiers to be established for plans, practitioners, providers, and patients. An information system is envisioned that will be able to collect data from all encounters, using a standard format with an emphasis on electronic records. Encounter data is to be transmitted to regional information network, to be used to set national info trends. A national data advisory committee for research is established. 	<p>AMA supports forward movement in electronic data management and administrative simplification to allow physicians and other health care professionals more time for patient care activities. These efforts are necessary to improve access and help contain health care costs, but it is critical that meaningful clinical management information systems be preserved. Through the development and maintenance of the AMA's CPT coding system, the medical profession has demonstrated its ability to create and administer an efficient procedure coding system in partnership with the government. CPT already is widely used and accepted by Medicare, Medicaid, and all major third-party payers. The national board should recognize the profession's contribution and be careful not to create new administrative burdens in the course of trying to simplify information systems.</p> <p>We are also concerned that, while private payors are given the responsibility for adopting EDI standards, a time limit is set for its adoption. We are confident that the private sector is developing and quickly integrating EDI without government involvement. No new unique identifiers should be created by the government. Physicians already are identified by Medicare/Medicaid UPIN numbers, and SPIN (Standard Prescriber Identification Number - an AMA/private sector initiative to create a unique identifier for claims processing and drug utilization review) is receiving a favorable response as a solution to the need for uniquely identifying prescribers. Accepted identifiers need not be duplicated. As with other EDI issues, assuring patient confidentiality will continue to be a goal of the AMA.</p> <p>There should be no micro-management of the information system at the national level. The costs of developing any information management systems should be kept to a minimum and not shifted. Confidentiality must be assured.</p>
<p>Quality</p> <ul style="list-style-type: none"> A national quality management program is set, to be overseen by a 15-member advisory council to the national board, consisting of consumers, plan reps, states, and public health and quality experts. National performance goals, minimum standards, research support, and a report on quality are required. Advisory council must set national program to develop practice guidelines, scientific standards, and priorities. Program is "customer-focused," based on consumer satisfaction and outcomes. Plan info collected by alliances is to be used to compare plans. Program publishes results of all plans annually. Regional data centers created. States enforce standards. National regulation preempts local regulation; intervention must focus on problems, with targeted reviews and randomly selected validation sites; demo program required by 1/1/96. Medicare PROs continue until HHS determine they are no longer necessary. NIH funding expanded for effectiveness and outcomes based on quality, with a program to evaluate reform and program to study how consumer choice and decision-making take place. 	<p>AMA recommended a comprehensive program that would recognize the profession's well-established accrediting and quality assurance programs. The AMA is deeply concerned that physicians have not been included specifically in the advisory council that will be responsible for so many initiatives in quality, especially the establishment of practice parameters. We will work to ensure that such efforts continue to be led by the profession. We are hopeful that HHS will quickly come to the conclusion that Medicare PROs are not cost effective.</p>

The President's Program	AMA's Response
<p>Scope of Practice</p> <p>Scope of professional practice continues to be based on state laws. However, HHS must develop and encourage state adoption of a national model professional practice statute for advance practice nurses and physician assistants. States may restrict the practice of health care professionals only on the basis of competency.</p>	<p>The AMA opposes any federal efforts to duplicate or supplant states' responsibility to ensure their residents' health and safety through national professional practice standards. States are in a unique position to react to their specific health care needs, and deciding the appropriateness of professional practice is a key means of assuring the safety and quality of health care in a state. Federal standards must not supplant state authority or criteria.</p>
<p>Physician Workforce</p> <ul style="list-style-type: none"> • After 5-yr transition, 50% of physicians in training must be in primary care. Phase-in requires primary slots each yr. to increase 7% and specialty slots to decrease 10%. • HHS allocates positions based on recommendations of new national council on graduate medical education; national council allocates positions to regional councils, which distribute positions to programs. Allocations based on program quality, relevance of training programs to actual practice, minority representation, and participation of locally coordinated plans. Programs with more slots than assigned receive no national GME funding. HHS has veto over allocations. Allocations good for up to 3 yrs. • National council members must include educators, practicing physicians, hospital administrators, program directors, nurses, others. Views of national professional associations must be sought. Regional councils include reps from health alliances, teaching programs, consumers. • Financing: insurer and Medicare pooled GME funds (\$6 billion) are made to programs, not institutions, to encourage out-of-institution programs. Transition payment made to hospitals that have reduced positions to replace residents with other staff, beginning at 150% of avg resident amount in first yr. • Primary care incentives: primary practice loan forgiveness; development of primary care retraining; special emphasis for minorities and community training at undergraduate level and continuing medical education; double training positions for nurse practitioners, nurse mid-wives, and physician assistants; special emphasis for mental health/substance abuse prevention, geriatrics, school-based health care, community care, and managed care. • Medicare primary care incentives: reduce payment rates for office consultations with savings transferred to increase reimbursement for office visits; increase office visit RVUs to cover pre- and post-visit time and reduce RVUs for all non-primary care services to maintain neutrality; resource based overhead component; increase primary care MPVS for primary care to GDP per capita + 5% in 1995; increase 10% bonus for nonprimary care in urban shortage areas and double bonus to 20% for primary care in all shortage areas; reduce outlier intensity procedures. 	<p>The program would federalize the nation's system of medical education. While more primary care physicians are needed, the AMA opposes arbitrary quotas restricting individuals' free choice to pursue their chosen fields. The reasons some physicians do not choose primary care are complex and involve lifestyle, practice environment, educational background, levels of educational debt, future income, and meeting personal goals based on individual interest. So a multi-faceted approach to stimulate interest is needed. Federal centralized decision-making will not guarantee an adequate supply of primary care physicians. Allocations are best made based on local needs and institutions' ability to provide an acceptable educational experience.</p> <p>While the idea of a national council may have some merit, it should be advisory in nature and its composition reflect those knowledgeable about medical education. Regional councils predominantly made up of physicians could be established to make advisory recommendations. The size should not be excessive; regional health planning bodies with wide representation demonstrated the political nature of such groups, resulting in ineffective function. HHS should not have veto power. Regional council decisions should be advisory.</p> <p>AMA opposes</p> <ul style="list-style-type: none"> • differential payment to programs based on specialty • the use of accreditation bodies to rank programs by quality: the concept is not yet developed sufficiently to be effective • federal prohibition of independent funding of GME positions; changes in need for physician training may require flexibility in seeking funding • allocating funds to individual programs, which would fragment the system and create a large, inefficient bureaucracy; allocation of funds to consortia that include medical schools would provide more effective coordination and evaluation of programs. <p>RBRVS should not be manipulated to achieve allocation goals.</p>

The President's Program	AMA's Response
<p>Academic Health Centers</p> <ul style="list-style-type: none"> • Medicare funds and a surcharge on private health plan premiums (\$6 billion) are to be collected as a fixed percentage add-on to help academic hospitals. • Medicare payments to teaching hospitals to compensate for uninsured and disproportionate share are reduced. • A national pool is established to support institutional research positions for specialized care • Health plans must cover routine costs of approved clinical protocols and have agreements with academic health centers to care for certain diseases in patient populations to assure access to academic health centers. Regional health alliance must monitor. 	<p>AMA supports assistance to academic health centers based on the additional costs of providing tertiary care. AMA also supports the requirement that plans have an agreement that ensures access to academic health centers when needed. Special attention must be given to the transition period until an entire system of health care reform is implemented, so that elimination of disproportionate share funding for indigent care does not create excessive hardship</p>
<p>Public/Preventive/Rural Health Initiatives</p> <ul style="list-style-type: none"> • NIH funding for prevention and health research services are expanded. • With universal coverage, public health depts can do data collection, surveillance, environmental protection, housing, food/water supply, epidemiology monitoring, emergency response. State formula grants established. • States encouraged to develop state health education programs to assure proper licensure, training, community focus. • Alliances can sponsor plans in rural areas. • Rural health professional incentives include nonrefundable personal \$1000/mo tax credit for physicians (\$500/mo for nurse practitioners and physician assistants); NHSC loan paybacks excluded from income; \$10,000/yr tax allowance for equipment purchased in HPSA; student loan interest deduction up to \$5000/yr 	<p>The AMA has long called for these kinds of incentives, especially in rural areas. Similar initiatives in currently underserved urban areas must not be ignored.</p>
<p>Workers' Compensation/Auto Injury</p> <p>Health plans provide treatment for medical services under workers' compensation and auto insurance policies and are reimbursed at negotiated fee-for-service alliance schedule with no copayments. States must determine workers' compensation benefits. Under workers' compensation, state freedom-of-choice provider laws are preempted.</p>	<p>The AMA opposes the preemption of state freedom-of-choice provider laws under workers' compensation. Without such laws, workers will be forced to see physicians who will not be their personal physician. Continuity of care, and thus quality of care, may be seriously challenged.</p>
<p>Supplemental Insurance</p> <p>Two types of supplementary insurance are allowed -- benefit supplemental insurance and cost-sharing supplemental insurance. Only plans that have high cost sharing options may offer both. Only high cost sharing can offer supplemental cost sharing insurance. Added benefits supplemental insurance may not duplicate coverage, community rating generally required, no exclusions allowed. National health board regulates.</p>	<p>The AMA supports consumer protections for supplemental insurance similar to those now established for Medigap. The plan should recognize the expertise of state insurance commissions and the NAIC. The AMA objects to a centralized national board approving all supplemental policies. Freedom-of-choice requires that the government not restrict the availability of supplemental policies as long as consumer protections are maintained.</p>

The President's Program	AMA's Response
<p>Clinical Labs</p> <ul style="list-style-type: none"> • Inspections required for labs performing 50,000 or more tests per yr doing critical testing where answer needed quickly, where erroneous results would lead to serious harm, where testing done to monitor care. • Exempt labs doing waiver tests/microscopic tests no longer have to register or be involved at all. • Limited license practitioners allowed to be added to microscopic category. • More tests added to waiver category. • Existing personnel grandfathered. • Proficiency testing education, with action only if extremely poor. • Study to modify the cytology proficiency standard. • Inspection focus shifted from all labs to high risk labs. • Announced inspections are under review. 	<p>The AMA believes that the CLIA program is a costly bureaucratic burden and should be repealed. But if CLIA must continue, these provisions are consistent with changes the AMA believes are necessary and has been working to bring about.</p>
<p>Long-Term Care</p> <p>Home and community care program for all ages included in benefits package. States may design their community based services system. Sliding-scale co-insurance required. HHS sets a national budget for home and community based services and allocates funds to the states; annual increases generally the same as national budget.</p>	<p>Again, placing a national budget on health care services is not acceptable. Further, the need for long-term care services will not be fully met unless a program is established to finance all long-term care services, not only home and community care. Due to the custodial nature of such services, long-term care must be addressed separately from medical concerns.</p>
<p>Liability Reform</p> <ul style="list-style-type: none"> • Patients must submit claims through an alternative dispute resolution (ADR) system each health plan must establish using models developed by national board. Complaint may be pursued in court after ADR. • Suits must include certificate of merit affidavit signed by medical specialist in field relevant to claimed injury that care deviated from established standards. • Attorneys' fees limited to 33 1/3% or lower state limit, if imposed. • HHS must set rules for public access to info contained in National Practitioner Data Bank. • Collateral source rule: recovery amounts must be reduced by amount received from other sources. • Either party may request awards to be paid in periodic installments. • State enterprise liability demonstration projects receive federal funds. • HHS authorized to develop pilot program to test effectiveness of using practice guidelines adopted by the new national quality management program, which is an expansion of the new Maine experiment. Physicians demonstrating compliance with guidelines not liable. HHS may work with states to invest practice guidelines with the force of law in pilot program. 	<p>The President's plan has not met the need to address the continuing liability crisis in health care. To ensure that the high cost of excessive litigation and awards does not continue under a new health care system, AMA has proposed initiatives similar to actions taken in California under its MICRA, including a \$250,000 limit on noneconomic damages and more stringent limits on attorneys' fees. Setting the limit on attorneys' fees at 33 1/3 percent is no limit at all, since this is the typical share of awards that attorneys take from their clients now. We are also concerned that health plans and not states are responsible for establishing ADR programs, such responsibility should be given to an impartial state authority. The AMA is opposed to opening the Practitioner Data Bank to the public. We are also opposed to enterprise liability, since it does not address the costs of the liability crisis, only shifts who pays for liability premiums. Providers following clinically relevant guidelines developed by professional associations should be allowed to raise such compliance as an affirmative defense in liability actions.</p>

The President's Program	AMA's Response
<p>Antitrust Reform</p> <p>A Small hospitals may merge. DOJ/FTC must publish guidelines providing safety zones for hospital mergers and joint ventures, including the analysis used, and expedited reviews and advisory opinions.</p> <p>B DOJ/FTC must publish guidelines providing safety zones for physician network joint ventures with less than 20% market share and that share financial risk, with examples of acceptable ventures, expedited business review or advisory opinion procedure. Within the safety zones, physicians may bargain collectively with health plans about payment, coverage, decisions about medical care, and other matters without fear of federal enforcement of the antitrust laws.</p> <p>C During transition, physicians/other providers allowed to negotiate with health plans: narrow safe harbor established to negotiate prices if they share financial risk (but not only fee discounting); physicians providing benefit package services may combine to establish or negotiate prices if they share risk and their combined market share is less than 20%. These safe harbors do not apply to implicit/explicit threat of boycott.</p> <p>D DOJ/FTC must publish guidelines for applying "state action doctrine, where states grant antitrust immunity to hospitals/institutions.</p> <p>E DOJ/FTC must publish guidelines describing under existing law providers' ability to collectively negotiate fee schedules with the alliances.</p> <p>F Health insurers' anti-trust exemption under current law is repealed so they no longer can collectively determine their rates.</p>	<p>These provisions are insufficient in letting physicians compete in what will be, under this plan, a health care system dominated by large corporate managed care entities. Provisions must be included that allow physicians to collectively negotiate with these large entities, as well as for the AMA and other societies to negotiate on behalf of physicians.</p> <p>A Allowing small hospitals to merge may allow them to have dominant market power in most communities. Further consolidation will only enhance this control and provide far too much leverage over physicians in negotiations.</p> <p>B Guidelines for physician network joint ventures may be useful. AMA has proposed detailed guidelines for safe harbors for physician networks. Clear-cut examples are needed, including efficiencies associated with clinical patient management using practice parameters, referral protocols. Formula for calculating physician market share also needed.</p> <p>C A carefully crafted definition is needed for financial risk sharing, e.g., accepting capitation contracts, contracts with fee withholdings related to utilization goals, and investing equity interest in the network itself.</p> <p>D The state action doctrine should be more broadly written.</p> <p>E Useful</p> <p>F Useful</p>
<p>Fraud and Abuse</p> <p>A DOJ/HHS jointly coordinate federal/state/local fraud and abuse law enforcement activities.</p> <p>B Current Medicare/Medicaid anti-kickback statute expanded to all payers; civil monetary penalties added; exceptions to include at-risk payments, all "downstream" payments made to provider in at-risk plan.</p> <p>C All self-referrals prohibited, except on at-risk basis.</p> <p>D Federal authority is expanded to include forfeitures of fraud proceeds, and new law modeled after existing mail and bank fraud law, including \$10,000 civil monetary penalties.</p> <p>E Medicare exclusion provisions apply to all health plans.</p> <p>F Standard of knowledge is "knows or should know."</p>	<p>A Comprehensive efforts to combat fraud in public and private sectors are supported, but HHS IG authority or civil money penalties should not be expanded to the private sector. Government agency coordination is acceptable.</p> <p>B Appropriate for criminal penalties for intentional kickbacks for all payers.</p> <p>C Generally support ban on self-referrals but need exceptions in situations where there is a demonstrated community need and where alternative financing unavailable.</p> <p>D Forfeiture of proceeds of fraud is acceptable, but not RICO confiscation. Support bank-fraud model.</p> <p>E Exclusion procedures should apply to all payers for criminal convictions except in cases where loss of provider would put patients at risk of no access. The HHS Secretary should not be authorized to exclude providers from private plans unless there is a criminal convictions or there is an immediate and grave risk of harm to patients. Otherwise, the Secretary could deny a livelihood for simple failure to comply with various Medicare/Medicaid rules.</p> <p>F Standard of knowledge should be "intent to commit fraud" so that honest errors without criminal intent are not handled as criminal matters.</p>

The President's Program	AMA's Response
<p>Medicare/Reductions in Reimbursement</p> <p>A. States may integrate Medicare beneficiaries into alliances if coverage is same or better. Alliances must offer at least 1 fee-for-service option offering Medicare.</p> <p>B. Individuals may remain in alliance upon reaching age 65</p> <p>C. Payment methodology to increase payment under the Medicare managed care program.</p> <p>D. By 7/1/96, Medicare will cover outpatient prescription drugs under Part B, with \$250 deductible, 20% co-pay, capped at \$1000/yr. Drug manufacturers must sign rebate agreements for difference between retail/non-retail markets. Reimbursement set at 90th percentile of actual charges.</p> <p>• Reductions in reimbursement:</p> <p>E. Delete volume and intensity from MVPS formula.</p> <p>F. Establish cumulative expenditure goals for physician expenditures.</p> <p>G. Reduce Medicare fee schedule conversion factor by 3% in 1996, with primary care services exempt.</p> <p>H. Establish prospective payment for hospital outpatient radiology, surgery, and diagnostic services.</p> <p>I. Reduce Hospital Market Basket Index update by a further 0.5% in 1997 and 1% in 1998-2000.</p> <p>J. Reduce IME Adjustment to 5.65% in 1995 and 3.0% in 1996 and thereafter.</p> <p>K. Reduce hospital inpatient capital payments.</p>	<p>A/B The AMA supports Medicare as a secondary payor, but beneficiaries should not be forced into other coverage situations. If the alliance would impose limits on access to physicians or other providers, beneficiaries should be apprised of this situation and have the opportunity to keep existing Medicare coverage.</p> <p>C Medicare now gives a higher level of coverage for care provided through a managed care entity. If care is equal, so should coverage and fee-for-service should be given parity.</p> <p>D The AMA supported drug coverage added as part of the Medicare Catastrophic Coverage Act. The primary AMA concern was patient access to the complete range of drug/biological regimens. HHS should not be allowed to limit such access to certain drugs.</p> <p>Reductions in Medicare reimbursement are unacceptable. Not only are these savings inadequate to finance health reform, they will sacrifice Medicare beneficiaries access to care. The cuts as proposed will continue the tradition of cost shifting Medicare costs to the private sector.</p> <p>E Oppose. Eliminating volume and intensity from the MVPS formula presupposes that these factors are never legitimate occurrences. It would penalize physicians for program growth beyond their control.</p> <p>F. Unclear. If this would prevent annual MVPS rebasing, it would be at odds with the original intent to base, in part, annual updates on actual expenditures.</p> <p>G. Oppose. This is another arbitrary reduction in Medicare that has no relationship to any likely reduction in the cost of providing care.</p> <p>H. Oppose. Setting related physician services on a prospective basis places all economic incentives against patients. The AMA has long opposed prospective payment for physician services.</p> <p>I. Oppose. The AMA historically has opposed hospital updates below the market basket.</p> <p>J. Oppose. The AMA has supported a 0.7 reduction in the 7.7% IME adjustment, with a follow-up study to determine a payment amount and equitable accounting methodology.</p> <p>K. Unclear. The AMA supported the OBRA-93 extension of the current 10% reduction in payments for the capital-related costs of outpatient hospital services, which previously applied through FY 1995, through FY 1998. We generally support reasonable payments for hospital capital expenditures.</p>

The President's Program	AMA's Response
<p>L Phase-down Disproportionate Share Hospital adjustment by 1998.</p> <p>M Expand centers of excellence.</p> <p>N Lower home health cost limits to 100% of median by 7/1/99</p> <p>O Competitively bid for all Part B lab services, except in rural areas, and other Medicare services.</p> <p>P Extend Medicare Secondary Payor Provisions for ESRD patients.</p> <p>Q Increase Part B premiums for individuals with income above \$100,000 and for couples with incomes above \$125,000.</p> <p>R 10% coinsurance for home health visits more than 20 days after discharge; 20% coinsurance for lab services.</p> <p>S Subject all state/local employees to HI tax.</p> <p>T Set Part B premium into law.</p>	<p>L Unclear. This adjustment may become increasingly unnecessary if Medicare acute care coverage is shifted from state Medicaid programs to alliances.</p> <p>M Unclear. While the AMA recognizes that such centers naturally develop, efforts to arbitrarily establish a center can overlook existing capabilities, and may stifle competition that actually serves to increase access to care by decentralizing care sites.</p> <p>N Unclear. However, by shifting payment for these services based on a national median overlooks the highly labor intensive nature of the care provided, resulting in overpayment and underpayment for these services based on where the care is provided.</p> <p>O Oppose. Medical services, including clinical lab services, are highly personal, and do not lend themselves to competitive bid. Patients should not have options for these services limited based on price, as opposed to quality.</p> <p>P Support.</p> <p>Q Support.</p> <p>R Support. Medicare payment of the 20% coinsurance for lab services was enacted as a quid pro quo for requiring that these services be furnished strictly on an assigned basis. With application of coinsurance for these services, the mandatory assignment requirement should be lifted.</p> <p>S Support.</p> <p>T Unclear. The AMA has supported an income-sensitive Part B premium and maintaining payment levels for the premium at a level to achieve at least the current 25% of costs for aged beneficiaries. (Without a change in current law, premiums would decrease in 1999.)</p>
<p>Tax Subsidies</p> <p>Employer contributions toward premium/cost sharing of benefit package are tax deductible to the employer and not counted as income to the employee. When alliances are established, tax deduction is allowed only if contribution is made through an alliance. Benefits exceeding benefit package are taxable to the employee; but if benefits provided as of 1/1/93, tax preference allowed for 10 years.</p>	<p>AMA supports a cap on the tax advantages given for health insurance premiums. Such a cap establishes a limit on tax support, but continues to allow individuals the right to seek additional coverage with their own after-tax dollars. Such a cap will improve consumer decision-making since expenditures beyond the cap are not subsidized.</p>

Chairman STARK. Thank you.
Ms. Johnson.

**STATEMENT OF GWENDOLYN JOHNSON, M.A., R.N., MEMBER,
BOARD OF DIRECTORS, AMERICAN NURSES ASSOCIATION**

Ms. GWENDOLYN JOHNSON. Good afternoon.

Mr. Chairman and members of the committee, I am Gwendolyn Johnson, a member of the board of directors of the American Nurses Association. Thank you for the opportunity to discuss health care reform.

The American Nurses Association is the only full service professional organization representing the Nation's 2 million registered nurses. ANA is proud to support the Clinton administration's health care reform plan.

We are also testifying today on behalf of the following organizations: The American Association of Critical-Care Nurses, the American Association of Nurse Anesthetists, the American Association of Colleges of Nursing, the American Association of Operating Room Nurses, Inc., the National League for Nursing, the National Nurse Practitioner Coalition, and the Wound, Ostomy and Continence Nurses Society.

Mr. Chairman, we are pleased to appear before this subcommittee as you begin to decide how, not whether, to reform our Nation's health care system, and we commend the members of the subcommittee for their leadership in advancing the debate on health care reform.

ANA is pleased that a number of members of this subcommittee have introduced or cosponsored bills that propose a variety of different approaches for reform of the health care system. This will indeed ensure that this issue is comprehensively discussed and that all options are thoroughly considered.

America's 2 million registered nurses deliver many essential health care services in the United States today in a wide variety of settings, and know firsthand of the inequities and problems with our Nation's health care system. Because we are there, 24 hours a day, 7 days a week, we know all too well how the system succeeds so masterfully for some yet continues to fail shamefully for all too many others.

Like President and Mrs. Clinton and so many Members of Congress, America's nurses believe that it is time to frame a bold new vision for health care.

Like the administration, nursing believes that universal access to health care services is a principle that cannot be compromised. For any health care reform plan to be successful, it is critical that it address not only access to health insurance but also access to health care services. Under the administration's proposal, the health care setting could be restructured and reoriented so that services would be available in schools, work places and community settings as well as in hospitals and providers' offices. Consumer access to health care services must be maximized.

A cornerstone of "Nursing's Agenda for Health Care Reform" has been the guarantee of a standard health benefits package. This is a critical point of agreement with the administration's plan, which places new emphasis on primary care and preventive services deliv-

ered not only by physicians, but also by nurses and other qualified health providers in convenient, accessible settings.

However, we do have some concerns about the mental health benefits package, the full integration of long-term care in reformed health care settings and the schedule of screenings that are proposed for reproductive health cancers.

The expanded role of nurses in the reform health care delivery system is apparent throughout the President's proposal. It is an important element of the plan's emphasis on preventive health services, services which have been at the center of nursing practice since the inception of our profession.

However, the ability of nurses to provide health care services has been continually hampered by a number of artificial barriers that serve to cut off the consumer from access to the services of these providers. These barriers include restricted reimbursement policies based upon specialty or geographic location and State restrictions on nursing practice.

The President's plan would address this problem by preempting the barriers to practice by providing incentives for States to adopt a Federal model for nursing practice statutes, and by including payment for services of advanced practice nurses, such as nurse practitioners, certified nurse midwives, and clinical nurse specialists.

We must guarantee that barriers to health care for the Nation's elderly be removed. ANA was pleased to have the opportunity to work closely with members of the Ways and Means Committee to achieve enactment of the Rural Nursing Incentive Act that allowed nurse practitioners and clinical nurse specialists who practice in rural areas to receive direct reimbursement under Medicare.

That law now needs to be expanded to cover the services of all nurse practitioners and clinical nurse specialists, regardless of geographic location and practice setting. This expansion of coverage does not provide for reimbursement for new services but rather provides for reimbursement of existing services in alternative cost-effective settings by nonphysician providers. By taking this action these advanced practice nurses would be able to provide essential services to meet the health care needs of those older Americans who currently have no access to affordable health care. Legislation to achieve this objective has been introduced in both houses of Congress this year. We urge you to insure that this important provision is incorporated into the health care reform package.

A very recent Gallup Poll revealed that the vast majority of Americans—86 percent—are willing to receive many of their every day health care services from an advanced practiced registered nurse that they now usually go to a physician to receive.

Mr. Chairman, we commend the subcommittee for holding this hearing and for working so diligently to find solutions to the health care crisis. We appreciate this opportunity to share our views with you and look forward to continuing to work with you as comprehensive health care reform legislation is developed.

Thank you.

[The prepared statement follows:]

**TESTIMONY OF THE AMERICAN NURSES ASSOCIATION
BEFORE THE HEALTH SUBCOMMITTEE
OF THE HOUSE COMMITTEE ON WAYS AND MEANS
ON HEALTH CARE REFORM
OCTOBER 7, 1993**

Mr. Chairman and members of the Committee. I am Gwendolyn Johnson, MA, RN, C, on member of the Board of Directors of the American Nurses Association (ANA). Thank you for inviting us to testify today on President Clinton's health care reform proposal.

The American Nurses Association is the only full-service professional organization representing the nation's two million registered nurses including staff nurses, nurse practitioners, clinical nurse specialists, certified nurse midwives and certified registered nurse anesthetists. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, projecting a positive and realistic view of nursing, and by working closely with the U.S. Congress and regulatory agencies on health care issues affecting nurses and the public. ANA is proud to support President Clinton's health care reform proposal.

Access to high quality, affordable health care is of concern to millions of Americans -- not only to the over thirty seven million who are uninsured, but to the growing number of currently insured who fear that changing or losing their jobs will result in loss of coverage or that skyrocketing costs will make their dependent's coverage or their own out-of-pocket health care costs unaffordable.

We are also testifying on behalf of the:

- * **American Association of Critical Care Nurses (AACN)**, the largest specialty nursing association in the United States with over 78,000 members who are dedicated to the welfare of people experiencing critical illness or injury. AACN has pledged its strong support of the Clinton Administration's health care plan.
- * **American Association of Nurse Anesthetists (AANA)**, the professional society that represents over 24,000 certified registered nurse anesthetists (CRNAs), which is 96 percent of all nurse anesthetists who practice across the United States. AANA's Board has voted to support President Clinton's health care plan.
- * **American Association of Colleges of Nursing**, with over 450 members offering baccalaureate, master's, and doctoral nursing education;
- * **Association of Operating Room Nurses, Inc.**, the professional organization of 48,000 perioperative nurses dedicated to enhancing the professionalism of perioperative nurses, promoting standards of perioperative nursing practice to better serve the needs of society and providing a forum for interaction and exchange of ideas related to perioperative health care;
- * **National League for Nursing**, with 1,620 nursing schools, 17 constituent state leagues, 104 health care institutes and 15,000 individual members;
- * **National Nurse Practitioner Coalition**, a group of nurse practitioner organizations who advocate for universal access to basic health care and the removal of barriers to consumer access to nurse practitioner care; and
- * **Wound, Ostomy and Continence Nurses Society**, an association of nurses who specialize in the prevention of pressure ulcers and the management and rehabilitation of persons which stomas, wound, and incontinence.

America's two million registered nurses deliver many essential health care services in the United States today in a variety of settings -- hospitals, nursing homes, schools, home health agencies, the workplace, community health clinics, in private practice and in managed care settings. Nurses know firsthand of the inequities and problems with our nation's health care system. Because we are there -- twenty-four hours a day, seven days a week -- we know all too well how the system succeeds so masterfully for some, yet continues to fail shamefully for all too many others.

Like President and Mrs. Clinton, the members of this Committee and many others, believe that it is time to frame a bold new vision for reform -- one that keeps what works best in our current system, but casts aside institutions and policies that fail to meet present and future needs -- a plan that addresses the triad of problems that exist in the current system: inequitable and limited access, soaring costs and inconsistencies in quality and appropriateness of care delivered.

NURSING'S AGENDA FOR HEALTH CARE REFORM

For the last five years, nursing has worked to develop a plan which encompasses the profession's best vision of a health care system for the future. To date, in addition to ANA's state and territorial associations, more than 80 national nursing and health-related organizations have endorsed this proposal for health care reform, entitled "Nursing's Agenda for Health Care Reform".

Nursing defines the health care crisis in terms of the need to restructure, reorient and decentralize the health care system in order to guarantee access to services, contain costs and ensure quality. Fundamental restructuring must occur because patchwork approaches have failed. Health care reform must be comprehensive and not limited to addressing only one or two components of the problem. Nursing's proposal does not define the problem only in terms of the uninsured or underinsured; rather, it addresses the health care needs of the entire nation. It is nursing's belief that the system must emphasize and support health promotion and disease prevention and show compassion for those who need acute and long-term care.

Among the basic components of "Nursing's Agenda for Health Care Reform" are the following:

- * universal access for all citizens and residents provided through a restructured health care system;
- * a federally-defined standard package of health care services including preventive, prenatal, well-child, mental health, acute and short duration long-term care services;
- * guarantees that coverage is provided for the poor with a plan administered by the states in order to anticipate the health care needs and changing demographics of the population. Elimination and restrictions on co-payments and deductibles for those near or under the poverty level;
- * an employer mandate to ensure that all employed persons have access to health insurance with a standard benefits package;
- * a shift in focus to provide a better balance among treatment of disease, health promotion and illness prevention such as coverage for immunizations, prenatal care, and health screening which has proven effective in preventing costly and devastating disease (e.g., colorectal and testicular exams, pap smears and mammograms);
- * enhanced consumer access to services by delivering primary health care in community based settings. The new system would facilitate utilization of the most cost-effective providers and therapeutic options in the most appropriate settings;

- * Steps to reduce health care costs, such as:
 - ensuring consumer access to a full range of qualified health care providers;
 - providing early treatment and prevention services at convenient sites, such as schools, the workplace, and other familiar community settings;
 - reducing defensive medicine and unnecessary practices;
 - controlled growth of the health care system through planning and prudent resource allocation; and
- elimination of unnecessary bureaucracy and decreased administrative requirements through the use of uniform claim forms and electronic billing;
- * utilization of case management for people with continuing health care problems to promote active participation in their care and reduce fragmentation of the health care system;
- * provision of long-term care services of short duration and in addition to a program of extended care in order to prevent personal impoverishment. This proposal will require more shared community responsibility for care. It will prevent impoverishment due to extended long-term care needs;
- * insurance reforms are required to ensure improved access to coverage, including community ratings, affordable premiums, reinsurance pools for catastrophic coverage and other proposals to assist the small group market;
- * access to services are ensured by no payment at the point of service and elimination of balance billing in all health plans.

There are several key features of "Nursing's Agenda for Health Care Reform" that are very similar to provisions contained in President Clinton's health care plan, announced on September 22. We commend President and Mrs. Clinton, as well as members of the White House Task Force on Health Care Reform, for the time and effort they have devoted to this critical issue.

UNIVERSAL ACCESS

Like the Clinton Administration, nursing believes that universal access to health care services is a principle that cannot be compromised. The Clinton Administration proposal would ensure that health care would be available to everyone -- including those who are now uninsured, underinsured and those who are potentially uninsured.

For any health care reform plan to be successful, it is critical that it address not only access to health insurance, but also access to health care services. Under the Clinton Administration's proposal, the health care setting could be restructured and reoriented so that services would be available in schools, workplaces and community settings as well as in hospitals and providers' offices. Consumer access to health care services must be maximized. Consumer education must be prioritized to foster increased awareness and responsibility for personal health and self care and to provide a greater capacity for informed decision making in selective health care services. In addition, criteria for outcomes of care should reflect the joint perspective of both the health care consumer and the health care provider.

The plan's emphasis on preventive and primary care services is also crucial, because it means that consumers will have a relationship with a primary care provider including nurses, nurse practitioners, certified nurse midwives, etc., that begins when they are still well -- so that disease can be prevented whenever possible and so that the provider will be able to intervene earlier, to minimize the severity of illness.

We commend the Administration's plan for recognizing that there will be a greatly increased need for primary care providers in order to ensure access to care and for addressing this need in a comprehensive manner. The plan calls for increased funding for primary care providers — including advanced practice nurses such as nurse practitioners, clinical nurse specialists and certified nurse midwives. It also calls for removing barriers to the practice of these advanced practice nurses so that consumers' access to these much-needed services is not restricted.

We applaud these moves because they will greatly assist in achieving the goal of universal access to care. The role of nurse providers is very important to the issues of access to high quality health care. The health care system will need a substantial increase in hours of care of these providers.

We are also extremely pleased to see that the Administration plan has addressed the need for increased access to services in rural areas by creating incentives, including financial incentives for health care providers to serve in those areas. Again, nurse providers can play a key role in treating the newly insured populations under health reform.

As the members of this Committee know, there is a growing trend in this country toward part-time and intermittent employment. Unfortunately, such employment status has often meant foregoing benefits, including health insurance benefits. Women comprise the majority of these part-time employees. Nurses have not been immune to this trend, and nursing associations are very concerned about it. Increasingly, nurses in both full-time and part-time employment are losing their employment benefits including health insurance. We know of registered nurses employed full-time at \$10.00 per hour and with no health care benefits. Their salary does not permit purchase of individual insurance. Guaranteeing health insurance to all employees is something that is of great importance to nurses both as health professionals and as employees.

STANDARDS BENEFITS PACKAGE

A cornerstone of "Nursing's Agenda for Health Care Reform" has been the guarantee of a standard health benefits package. We are gratified that the Administration's proposal provides a guaranteed package of benefits, emphasizing a broad scope of quality health services, not just treatment of disease. It supports school-based clinics, enhanced services for underserved populations and health education. It includes such critical elements as home-based care and public health initiatives and also takes an important step toward addressing the growing need for better and more accessible long-term care services. In addition, the Administration's package includes such important preventive services as immunizations, screening and prenatal care. It places new emphasis on primary care and preventive services delivered not only by physicians, but also by nurses and other qualified health care providers in convenient, accessible settings.

By including services that are geared toward preventing and minimizing disease, the Administration's plan can save the health care system immense amounts of money and ensure a healthier population. One of the clearest examples of preventive care saving long term costs in the health care system is the provision of pre-natal care. Numerous studies have shown that receipt of adequate pre-natal care is associated with the improvements in pregnancy outcome, particularly a reduction in the risk of low birth weight infants. For example, California Department of Consumer Affairs has estimated that the State could save \$66 million annually in neo-natal intensive care unit charges if all women received adequate prenatal care.

We urge the Committee to act to ensure that full and complete reproductive health services are available to women and that preventive screening services, such as mammograms and Pap smears, be available in intervals that are sufficient to detect disease in a timely fashion.

THE ROLE OF THE NURSE PROVIDER

The expanded role of nurses in a reformed health care delivery system, including advanced practice nurses such as nurse practitioners, is apparent throughout President Clinton's proposal. It is an important element of the plan's emphasis on preventive health services--services which have been at the center of nursing practice since the inception of the nursing profession. Nurses are key providers in acute care, school and community health clinics, in home care, hospice care and ambulatory care, all of which are part of the package of benefits to be available under the President's plan.

Nurses, including advanced practice nurses, are well-positioned to fill many of the current gaps in accessibility and availability of primary and preventive health care services. There are approximately 100,000 advanced practice nurses with advanced education and training in providing primary care services. As many as 300,000 additional nurses could be prepared to provide such services with additional training.

Nurses often provide care to those who have no access to the current health delivery system. For example, the Family Nurse Practitioner Program at the University of California - San Francisco has developed a health services program in an inner-city homeless shelter for families. A nurse practitioner is the only health care provider for these families. She diagnoses and treats episodic health problems and has demonstrated that, with regular return visits to the Shelter's Clinic, many of the problems are kept from worsening and requiring hospitalization.

A family nurse practitioner in Washington, Kansas directs a clinic serving the critically underserved, as defined by the Kansas Department of Health and Environment. The physician director of this clinic left in 1986, and the clinic subsequently lost its Federal funding. At this time, the clinic is being leased by a country hospital from a non-profit corporation and has contracted with the nurse practitioner to run the clinic which includes eight fully-equipped exam rooms. Since a physician is not on the premises, the advanced practice nurse needs to be eligible for direct reimbursement of her services. As she serves in a rural area, she became eligible for reimbursement under Medicare in 1991. She also works through the Kansas Blue Cross and Blue Shield office, the state Medicaid Bureau, and other private insurers to obtain reimbursement under each of their systems. Currently, in the town of Washington, Kansas, there is only one family physician and only three physicians in the entire county. The nurse run clinic is essential to providing the citizens of Washington, Kansas with health care services.

In Chicago, there is a program called the Beethoven Project. This program occupies 10 renovated apartments in a Chicago public housing project which has a high level of poverty and crime. Comprehensive services, such as primary health care, Head Start, and a full-time child care center in addition to drop-in counseling, psychological consultation and care management are provided by the nurse directors.

However, the ability of nurses to provide health care services has been continually hampered by a number of artificial barriers that serve to cut the consumer off from access to services provided by these competent and qualified health providers. These barriers include restrictive reimbursement policies by Federal and state programs and private insurers, and they also include irrational restrictions on nursing practice such as physician supervision requirements by laws and regulations at the state level. The laws regarding reimbursement for advanced practice nurses are complicated and convoluted as to which categories of advanced practice nurses may be reimbursed, in what geographic areas, who may be paid and whether or not collaboration with other health providers is required. The current laws are so confusing and complex for carriers, providers and consumers that they have become a barrier to access to these services in and of themselves.

We must guarantee that barriers to health care for the nation's elderly are removed. ANA was pleased to have the opportunity to work closely with Members of this Committee, as well as with Members of the House Energy and Commerce and Senate Finance

Committees, to achieve enactment of the "Rural Nursing Incentive Act". That provision, which was included in the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) allows nurse practitioners and clinical nurse specialists who practice in rural areas to receive direct Medicare reimbursement under Medicare.

That law now needs to be expanded to cover the services of all nurse practitioners and clinical nurse specialists, regardless of geographic location and practice setting and regardless of whether they are associated with another health care provider. This expansion of coverage does not provide for reimbursement for new services, but rather provides for reimbursement for existing services in alternative cost-effective settings by non-physician providers. In addition, modeled after the bonus payment of physicians who work in health professional shortage areas (HPSAs), these practitioners would also be paid a bonus payment when they work in HPSAs. Extending bonus payments to non-physician providers has also been recommended by the Physician Payment Review Commission. By taking this action, these advanced practice nurses would provide essential services to meet the health care needs of those older Americans who currently have no access to affordable health care.

ANA has been working closely with Members of the House and Senate to achieve this objective. Legislation to provide direct Medicare reimbursement to nurse practitioners, clinical nurse specialists and certified nurse midwives has been introduced in the House by Reps. Ed Towns (D-NY) and Bill Coyne (D-PA) [H.R. 2386] and in the Senate by Senators Charles Grassley (R-IA) and Kent Conrad (D-ND) [S. 833]. The Congressional Budget Office has recently estimated that if Medicare reimbursement were extended to nurse practitioners, clinical nurse specialists, and certified nurse midwives at 85 percent of the physician fee schedule, and that if that Medicare reimbursement was also provided to physician assistants, the cumulative cost would be only \$117 million over a five-year period. That is a minuscule amount to expend to ensure that access to health care services would be available to individuals who might otherwise not be forced to forego those services.

Another example of payment inequities for nurses under the Medicare system is the lack of reimbursement for operating room nurses serving as assistants at surgery. The issues of Medicare reimbursement for registered nurses who assist at surgery has been an important issue for ANA and the Association of Operating Room Nurses since a provision was included in the Omnibus Budget Reconciliation Act of 1986 that permitted reimbursement for physician assistants who first assist at surgery. The ability of physician assistants to be reimbursed under Medicare has created employment disparity for nurses who provide the same service, but are not reimbursed under the law. Rep. Cardiss Collins (D-IL) has introduced legislation, H.R. 1618, to permit direct payment under Medicare Program for the services of registered nurses as assistants at surgery. We support this legislation.

In addition to the access problems confronted by our senior citizens, many Medicaid recipients are also being forced to forego essential health care services because health care providers are not available to them. In order to improve access to care under Medicaid, certain reforms in payment and coverage policy must be enacted by the Congress. At the present time, the Medicaid program mandates the coverage and payment of nurse midwifery, certified pediatric nurse practitioners and certified family nurse practitioners, but does not mandate the coverage of services furnished by other nurse practitioners, or by clinical nurse specialists and certified registered nurse anesthetists. The Medicaid program needs to directly reimburse for the services of these practitioners so that they may be utilized by Medicaid recipients.

Several states have changed their State Medicaid payment and coverage policies to encourage the use of these practitioners and have been able to increase access to care for vulnerable populations. For example, in New Hampshire, the services of nurse practitioners are covered by Medicaid and access to care is improved. Many physicians have a limit on the number of Medicaid patients they will accept in their practice and refer additional Medicaid beneficiaries to nurse practitioners who see them in their own practice or through well-child and pre-natal clinics. Some nurse practitioners in New Hampshire have a

caseload that is 90 percent Medicaid. The State's Medicaid payment policy also encourages the use of these practitioners. Since 1982, nurse practitioners have had their services covered by the Medicaid program at 100 percent of the physician rate. According to Charles Albano, Chief of the Bureau of Maternal and Child Health in New Hampshire, nurse practitioners are relied upon to provide the vast majority of services to low income women, 75 percent of whom are Medicaid recipients. Nurse practitioners are also used to staff the family planning clinics and the well-child services in the state.

Medicaid payment policy needs to be improved to increase access to care. Payments to nurses in advanced practice under the Medicaid program need to be based on the service and not on the type of provider. This policy in New Hampshire provides a positive incentive for pre-natal and well-child clinics to use nurse practitioners. Washington State has adopted a similar policy of payment based on the service.

In addition, Washington State changed its Medicaid fee schedule to improve access to care. In 1989, the State Legislature added \$200 - \$300 to the obstetrical package to offset malpractice costs and to improve recruitment of providers. In 1990, the policy was established to pay all providers the same rate for the same services. This had a significant effect on recruiting nurse practitioners and certified nurse midwives. There is no nurse midwifery educational program in the State, and yet the improved competitive fees were instrumental in bringing these practitioners into the State to staff the clinics. In two years, the number of certified nurse midwives increased by 33 percent and there has been a limited turnover of certified nurse midwives, despite their serving a high risk population.

Laws and regulations in many states place unnecessary restrictions on the practice of nurses, including advanced practice nurses, to provide services to patients, to provide routine care and medications, to bill insurance companies, to operate a private practice, to obtain clinical privileges or to admit patients to a hospital. For example, in Vancouver, Washington, one nurse practitioner provides health screening, immunizations and other services to over 2,000 poor children in five inner-city schools which she visits weekly in her mobile van. However, in other states, such as Illinois, this nurse practitioner could not perform these services, since State law prohibits her from being directly reimbursed by Medicaid.

Representative Bill Richardson (D-NM) has introduced a bill (H.R. 1683) to improve access to the services of nurse practitioners and clinical nurse specialists by mandating the coverage and payment of all nurse practitioner and clinical nurse specialist services under the Medicaid program. An identical bill (S. 466) has been introduced in the Senate by Senator Tom Daschle (D-SD). The Congressional Budget Office recently estimated that the cost of enacting this proposal would be \$46 million over a five-year period. That is a very small amount when compared to the value of increasing the access of Medicaid recipients to badly needed health care services.

Inconsistent state restrictions or prescriptive authority for advanced practice nurses are another barrier to health care and promote the costly use of an additional provider.

In addition to the general examples of barriers to practice just noted, there are three specific Medicare reimbursement barriers to practice that exist for certified registered nurse anesthetists (CRNAs). First, the current Medicare conditions of payment for anesthesiology services that anesthesiologists must meet in order to be paid for Medicare for medically directing a CRNA, restrict CRNAs from performing all the components of an anesthesia service that they are legally authorized to perform. For example, some anesthesiologists insist on performing the anesthesia induction on all patients themselves, then leaving the CRNA to finish the case. Second, the current Medicare hospital condition of participation for anesthesia services and the Medicare ambulatory surgical center condition of participation for coverage for surgical services restrict CRNA practice by requiring physician supervision of CRNAs. Third, the current Medicare regulation on payment for the services of CRNAs states that if a CRNA and anesthesiologist work together on one case, the anesthesiologist may bill the case as if he/she personally performed it and receive 100

percent of the Medicare payment. No Medicare payment is typically made to CRNAs involved in such a case, even if the CRNA was the provider actually administering the anesthesia to the patient.

Nurse managed units within acute care settings are also both cost effective and provide quality care. For example, nurse managed units are proving to be very successful in managing patients being weaned from respirators. In addition, studies have documented the positive outcomes demonstrated by the use of neonatal nurse practitioners with low birthweight infants.

The President's plan would address the problem of artificial restrictions on nursing practice by preempting such barriers to practice, providing incentives for states to adopt a federal model for nursing practice statutes, and by including payment for services of advanced practice nurses. It is our understanding that the Administration plans to shore up these provisions by ensuring that advanced practice nurses do not face exclusion or other discrimination by health plans and by extending Medicare coverage to the services of nurse practitioners and clinical nurse specialists in all settings.

Just as nurses throughout the United States have demonstrated their ability to provide high quality, cost effective and accessible health services, consumers have shown their widespread acceptance of these services and their willingness to continue receiving primary care services from nurses. A recent Gallup poll revealed that the vast majority of Americans (86 percent) are willing to receive everyday health care services from an advanced practice registered nurse that they now must go to a physician to receive. Only twelve (12 percent) percent said they would be "unwilling" to go to a registered nurse. Nurses are currently working with consumer-oriented organizations in order to promote shared principles of health care reform. We are confident that as the American public becomes more familiar with the primary care services that nurses can provide, and as more Americans have an opportunity to receive such care from nurses, that the "unwilling" category will decrease sharply. In fact, we believe that, based on the experiences of advanced practice nurses in HMO, clinic, and private practice settings, more and more Americans will identify nurses as their provider from whom they select to receive primary care services.

QUALITY ISSUES

As health care reform becomes a reality, hospitals and other health care institutions will experience increasing pressure to contain costs. As the focus of the health care delivery site shifts from acute-care institutions to community based care, there will be an increase of hospital mergers and closures of hospitals resulting from an oversupply of beds. It is anticipated that some hospitals will specialize and others will integrate services such as home health and nursing homes.

Nurses have had an opportunity to experience first-hand what many hospitals do when they face pressure to cut costs. In the last few years, nurses have grown increasingly alarmed at the wholesale reduction in quality of care that many hospitals have initiated in the name of cost-savings and cost-efficiency. Numbers of nurses have been cut and nurses have been laid off. In their place, hospitals have hired unlicensed, semi-skilled personnel, often trained by the hospitals themselves in brief training courses. While the use of unlicensed personnel to assist registered nurses is not new, hospitals in the last few years have greatly expanded the use of these personnel, both in numbers and in the range of functions they perform. This has happened at a time when, due to a number of factors, the severity of illness of the hospitalized patient population has increased significantly. As a result, registered nurses find themselves caring for and supervising care for ever-greater numbers of increasingly sick patients. This has meant a continual downgrading of care for patients, one which poses a real risk to their health and safety while hospitalized.

Many hospitals have openly stated--threatened, if you will--that they will increase the trend toward downward substitution if health care reform is enacted. We consider this not only a threat to the professional and economic security of nurses, but also to the patients we care for--patients who literally entrust their lives to the hospitals. We believe that hospitals must adhere to strict quality controls if patient care is to be protected. Hospitals should not be permitted to sacrifice patient care in the name of cost efficiency. We have received every indication that the Administration will work to institute mechanisms to protect and ensure safe, quality care both in the long run and in the period of transition to a reformed health care system. These mechanisms will include the development of patient outcome measures as well as, in the immediate period, criteria that monitor changes in hospital staffing and patient care delivery patterns to ensure that patient care is not compromised.

NURSING EDUCATION

Health care reform will require a refocusing of knowledge and skills for nursing faculty and future nurses. With greater emphasis on prevention and early intervention, as well as a decreased need for acute care nurses, nursing education will need to be re-focused on primary health care and the management of acute minor illness and complex chronic diseases. Skills in case management, discharge planning, supervision of health personnel, and financial planning will be essential. Fortunately, many nurses are skilled in these vital areas, but many more will be needed.

The trend that will occur in a health care reform environment which is of most significance to nurses is the shift in balance between episodic, high cost, specialty focused, hospital based tertiary care to primary and preventive care delivered in a range of ambulatory care settings by a variety of practitioners. This shift is already occurring, as witnessed by the rapid growth in home care and ambulatory care services.

Since World War II, the majority of nurses have been educated for and employed in hospitals. Significant educational efforts on both the part of individual nurses and the health system are now needed to focus on the delivery of primary health care services. The Administration has included several health provider education initiatives in their proposal. Under their plan, the Secretary of Health and Human Services will determine the estimated need of nurse workforce and advanced practice nurses needed to meet the current health care demands of the nation. This will be based on the workforce estimates developed by the National Council on Nurse Education and its allocated regional councils. To fund nurse education, new programs need to be established to increase the supply of nurses.

According to the National Sample Survey of Nurses (1988), there are approximately 125,000 registered nurses working in physician offices, freestanding clinics, ambulatory surgical centers, health maintenance organizations and other ambulatory care settings. In addition, there are approximately 11,000 registered nurses working in community/public health settings, 48,000 in school health, and another 22,000 in occupational health. With the appropriate funding support, this pool of generalist nurses could begin to rapidly increase the nation's supply of primary care providers.

Nursing commends the Clinton Administration for its increased focus on nurse education issues. It is clear that the United States health care system has an increasingly urgent need for primary care providers. Immediate funding must be made available to strengthen existing advanced practice nurse programs and to establish new programs to prepare the primary care providers so urgently needed.

The Administration's plan would shift the funding emphasis under Graduate Medical Education from specialty physicians to primary care physicians. Advanced practice nurses will be increasingly needed to fill the future gap created in this shift to primary care providers and in some specialty areas. For example, a reduction in the supply of physician anesthesiologists will require increased funding to educate a greater number of certified registered anesthetists.

Nursing has specifically recommended that an amount equal to 10 percent of direct Graduate Medical Education (GME) funds be pooled from all insurers and be used in a manner similar to that used in the GME program for physicians. These funds would be allocated to support the education and training of primary care nurses and specialty advanced practice nurses, such as certified registered anesthetists, who will be needed in greater numbers under the Administration's plan by allowing reimbursement of providers for faculty costs and student stipends through GME. This program would enable hospitals to maintain quality service and cost effectiveness within the constraints of the new system. This new program could be funded by a combination of Medicare contributions and a surcharge on health premiums. Because of the importance of advanced practice nurses to the delivery of care, a constant stream of dollars is needed to support the education and training of these providers on a basis similar and equal to resident physicians. Nursing believes that this fund must be in addition to the current Nurse Education Act program.

In addition to preparing primary care providers and other nurses, it is also of importance to ensure that there is an adequate supply of nurse educators, both at the undergraduate and graduate levels of education. Existing nursing faculty may need additional training themselves in order to become nurse practitioner and other advanced practice nurse educators.

Nursing strongly supports the Administration's stated intention to increase the cultural diversity of the health care workforce by supporting programs aimed at under-represented ethnic, minority and/or disadvantaged persons. The proposal supports efforts to recruit and retain students for nursing and other professions and to increase the number of minority faculty and researchers in the health professions.

ADMINISTRATIVE SIMPLIFICATION AND COST SAVINGS

Nurses throughout the nation breathed a collective sigh of relief when the President outlined the need to simplify the mounting paperwork and other administrative requirements that burden our health care system. We know firsthand what a waste of professional time these requirements can represent. Too often, nurses are forced to take time away from patient care and devote it to filling out forms. It has been estimated that a staff nurse fills out an average of 19 forms per patient. Thus, we applaud the President's proposals to pare down and simplify paperwork and other wasteful administrative requirements.

However, we need to draw a distinction here between completion of insurance forms and other activities that serve little other than facilitating the flow of paperwork and bureaucracy, and documentation that does facilitate maintaining and improving quality and patient care standards. The Administration's proposal would emphasize data collection that is related to quality of care, development of outcomes criteria and other activities that are directly relevant to patient care. As health care professionals, we regard this as important and necessary. The distinction we make is between needless and endless paperwork and the collection of patient care information that leads to continuous improvement in the quality of care. We are more than happy to give up the former and opt for the latter.

Nursing also supports the greater use of community rating, eliminating pre-existing conditions as a way for insurance companies to reject higher-risk individuals and limiting an individual's out-of-pocket expenses following a catastrophic health event.

CONCLUSION

Mr. Chairman, we commend the Committee for holding this hearing and for working so diligently to find solutions to the health care crisis. We appreciate this opportunity to share our views with you and look forward to continuing to work with you as comprehensive health care reform legislation is developed.

Thank you.

Chairman STARK. Thank you, Ms. Johnson. I had a question. You may want to submit this to us later, but in your testimony you talk about an average of 19 forms filled out for each patient. I would like to explore that for a minute, then ask you to please send me copies of those because my guess is those forms have largely to do with the health care of the patient.

My limited experience in hospitals has been that the insurance forms are filled out downstairs before you even get into the room, and that the nurses may be ordering tests, there may be entries for the medical record, there may be entries for malpractice insurers that are required to keep the doctors from losing all their money. But I don't know that any system is going to do away with many of those forms, and you do go on in your testimony to say that some forms are indeed necessary.

I think you are probably beginning to recognize the usefulness of automated patient records. I hope you are.

Ms. GWENDOLYN JOHNSON. Yes.

Chairman STARK. But there has been an implication that these 19 forms that the nurses fill out somehow have to do with a lot of useless paperwork relative to a payment system. Is that a fair characterization of those 19 forms?

Ms. GWENDOLYN JOHNSON. In many cases in hospital settings a lot of the forms are essential and necessary. I myself work as a staff nurse in a local area hospital. However, a lot of the time that is spent with patients is ensuring that they have the availability and the social supports necessary to meet the requirements related to—

Chairman STARK. I understand about social support, yes, but the inference is that somehow we are wasting a lot of your time and those are forms that could be filled out by any old clerk.

That isn't the case, is it?

Ms. GWENDOLYN JOHNSON. No, that is not the case.

Chairman STARK. That is what I thought. Those are some forms that take some technical training to understand, are they not?

Ms. GWENDOLYN JOHNSON. But I would also add, Mr. Chairman, that nurses working outside of hospital situations do have to fill out a lot of different forms.

Chairman STARK. In home health care?

Ms. GWENDOLYN JOHNSON. In home health care, in offices.

Chairman STARK. We have a lot of entrepreneurs in home health care, not doctors and hospital administrators, we have these guys who may sell a lot of unusual services and they may need forms for a lot of different reasons, but—OK. Well, if you would do me this favor, you are working now as a staff nurse, send me the forms you fill out and mark for me those which you feel are useless.

Ms. GWENDOLYN JOHNSON. Absolutely.

[The forms were submitted to Mr. Stark and will be retained in the committee files.]

Chairman STARK. I would like to see that. I think that would be very helpful.

OK. Gentlemen, nobody likes the premium caps.

You don't, do you? And you don't?

Dr. TODD. No.

Chairman STARK. I am going to ask you in any form that we know of what, scoreable, accountable system would you prefer on the private sector side to slow down the rate of growth which I think you both agree we have to do in spending. Which would you take, of those systems that are out there?

Dr. TODD. We would certainly stand behind the ability to sit down with those who are going to be regulating the payments or making the payments and try and look at what is the need out there in terms of appropriate care for patients, how it can be efficiently and effectively given, and what new technology is going to add to this and how that can be best used, and at the end of that, a series of negotiations, conversations, call them whatever you want, come out with something that gives us an expectation of what should be spent in the ensuing year.

Chairman STARK. Do you know of any format, any system that does that now?

Dr. TODD. The physicians in Canada have an opportunity to sit down with their government and negotiate the budgets for the following year. The doctors in Germany are able to sit down and negotiate with their Federal government, and where we would differ with what the Canadians and the Germans do is that at the end of that time if the budget was blown, find out why. Don't put in place, fix in place, the inequities and the shortcomings of the system by just ratcheting down the budget the following year.

Chairman STARK. I am not asking you for an endorsement, but haven't we come about as close to that in the system we have now in Medicare as any other system that at least exists in this country?

Dr. TODD. Well, with all due respect, Mr. Chairman, no, I don't think you have. I think—

Chairman STARK. Is there one that is closer?

Dr. TODD. We appear before this Committee on numerous occasions, we have numerous discussions, and then we have to wait and see what the final result is, and then we have to go through the reconciliation process which sometimes also changes our understanding.

Chairman STARK. They do the same thing in Germany. I am just saying there is no other system, in which you negotiate and end up with a set of fees in this country? I don't know of one.

I am not asking you to endorse that. I am just saying I don't know of any other structures, save the salary structure at an HMO, where we do it. Now, what your answer sounded to me like is we ought to think up one, but I don't think we know one. I am asking seriously if there is one in use in this country that you think looks better than any other. I don't think you have one, do you?

Dr. TODD. And I would agree we probably don't have one at the moment, but it doesn't mean we couldn't develop one.

Chairman STARK. Could we build on the Medicare structure?

Dr. TODD. To a degree.

Chairman STARK. Would you pick it as a starter or would you pick another one? I am saying this because you know I'm saying it, and I think that is where we have to start because it is the only system where we have some kind of a structure in place.

Dr. TODD. I think what we are trying to move for in health system reform is some degree of predictability, stability, understanding of each other's roles in the process, and that that really does take a great deal more of discussion and a better understanding when you leave the room of what the rules of the game are than to have them constantly changing.

Mr. DAVIDSON. Mr. Chairman, we have the potential.

Chairman STARK. You have the Maryland system, right, which is the best? Isn't that the best in the country?

Mr. DAVIDSON. Well, first of all, let me say a few things about Maryland since Mr. Cardin praised us so well.

Chairman STARK. Oh, you are brave.

Mr. DAVIDSON. I would much prefer to say this in his presence, but Sean is here and he will cover me. It took us 17 years to ultimately affect the dramatic rate of increase, and I think it is important. We started, well, it is wonderful for Mr. Cardin in come here and praise us.

Chairman STARK. In Maryland it took 17 years from the beginning of the system.

Mr. DAVIDSON. It took 17 years to achieve the measure of performance that they have today in that State.

Chairman STARK. After they put the system in or including the time it took to pass the system?

Mr. DAVIDSON. From the time ultimate rate authority took place, which was in 1976, until today, it took that many years, and that is an important lesson to learn in terms of the proposed arbitrary cap and how quickly you can get to something, and that was with a cooperative relationship, all right?

The other important learning, of course, that we had in the State of Maryland, was that we set out to focus on hospital costs—not medical costs, hospital costs. We did a very effective job of holding down hospital costs, but we didn't hold down medical costs.

In fact, the Maryland General Assembly just this past year enacted new legislation to begin to look at the regulation—potential regulation—of doctors' fees which told us that you can control one sector but you can't necessarily deal with the other side in volumes of service increased and so forth. The moral of that story, based back on your question in terms of predicting the future, is that we couldn't have predicted in 1976 how many years it would take to get to a particular target.

Chairman STARK. But you had to be below the national average in each of those years; didn't you?

Mr. DAVIDSON. No, no, we were 26 percent above the national average.

Chairman STARK. How did you get your waiver? I thought implicit in the waiver was that you were below the national average.

Mr. DAVIDSON. In terms of our rate of increase, but hospital costs in Maryland in 1976 by case were 26 percent above the national average.

Chairman STARK. But then your rate of increase was lower. That is all we are trying to achieve nationally.

Mr. DAVIDSON. Just to give you an idea of timing. The other example when you make reference to Medicare is the potential there for something in the Medicare program. You know, when PPS was

enacted in 1983, there were many of us who lobbied to have the Prospective Payment Commission have more authority with regard to its recommendations and their binding relationship to the Congress.

What we have experienced is that the Prospective Payment Commission has made recommendations with regard to payment that by and large we have found to be sound and then you all get in to the budget morass, as you well know, and ultimately this is a place that you can scale back, so when you raise the question is there a potential model that could be followed, PROPAC is a possible model.

The President proposes the creation of a national commission. If, in fact, you had a national commission of seven people who were judicial—then we could help learn to do that.

Chairman STARK. Do you know how many hospitals would be left if we had to have a PROPAC appointed by the past 12 years of administration and that PROPAC had followed the recommendations of the previous 12 years of administration? You would be down to 2000 members. Don't always suggest that because we change PROPACs. In fact, you will remember that this committee in every one of at least the 8 years that I have been sitting in this area has had far fewer cuts on hospitals and on doctors than the administration has recommended, and that was done with the bipartisan support of my minority side so that I would say, quite frankly, this committee, Congress, has saved your butt.

Mr. DAVIDSON. We should turn it around, Mr. Chairman, and say that needs to be binding on the President first. But the point is there is a possible model with response to your question, and all kidding aside, I think you know how we feel about your role in being an advocate for protecting hospital payments.

You have done that regularly and consistently, and we are very much appreciative of you and this committee. That is a subject that we have not ignored and there are possibilities of thinking through ways to have a government model evolve that does make some sense. It has to be binding on more parties, however.

Chairman STARK. Quickly, what do you guys think? Do you more or less support the idea of competing networks of health care providers in a little bit different way than the administration plan. How do you see the trauma centers and cancer centers and teaching centers and children's hospitals fitting into that?

Mr. DAVIDSON. I think when it comes to trauma, teaching and all the rest, we have got to find a way to carve out and subsidize those unique special services that perhaps ought to be outside the system and give those institutions more of a level playingfield so that they can be part of a network. I think consideration is being given to that.

It needs to be fleshed out a great deal more. It is essential that we maintain those services in communities. If we lose those, we will never regain them.

With regard to children's hospitals, I think we need to look at the same level of integration and examine that very carefully. There are a series of institutions when you look at rehabilitation and all of the rest.

We have our own hospitals all talking to each other and trying to think through that. I must tell you there is not a simple answer to that at this point in our history, but obviously we are going to be pressed to come up with some strong recommendations to you, and we will.

Chairman STARK. One for both of you, now. I will ask Jim first. In the President's plan, and indeed in the Jackson Hole plan, everybody talked about competing groups that are one way or another going to save money. None of them are going to save money by setting fees. They have all got some structure up there that is going to appear whether it is utilization or whether it is urging the members to exercise more, quit smoking or pray, whatever they have in mind, but my guess is that if you have multiple plans, every plan save Dr. McDermott's has in mind multiple plans, that each one of them is going to have a separate and distinct and unique utilization qualification review plan because that is all they have to sell.

They have price negotiation and they have a minimum stack of benefits. The only way they can do it is by having a different set of gatekeeper standards. I am not sure that that makes your issue of the hassle factor or setting standards of quality any easier.

Do you want to comment on that?

Dr. TODD. No question that there are many ways of going at savings and one is strict utilization review which looks at the dollars instead of the care that is given. But you begin to look at what sorts of care we are giving to whom and under what circumstances the more appropriate use of medical technologies. I am sure you have heard it before, these groups that seem to provide the best level of care in which the providers are the happiest and which the cost seems to escalate the least are those organizations that are run by physicians. And you have the Permanente group, Mayo Clinic, you have Virginia Mason, and you can replicate that over and over again.

And I think the profession is committed to looking at what they are doing, how much they are doing it and trying to make sure that the care they give is going to be beneficial. If you add to that the other cost-reducing factors in society, professional liability reform, administrative simplification, it can work.

I think you have seen that competition can work in the sense that health system reform has been going on in this country—

Chairman STARK. That isn't what I asked. What I asked you is do you think that having multiple plans will simplify the doctor's role in terms of dealing with a variety of utilization reviews and rules under which the physician will be operating?

Dr. TODD. I think in all honesty it depends upon who controls the plan.

Chairman STARK. There will be five different ones. CIGNA will control one, Medicare may control one, there may be a Kaiser that may control one. Any alliance or any HIPC will be studied to see what kinds of results they provide to their beneficiaries, but each one will have a separate set of rules and regulations under which your Members will operate.

How can that be simpler?

Dr. TODD. Hospitals have rules and regulations under which they operate and I think that the secret is allowing the physicians to establish those rules and to look at what it is they are doing instead of having somebody with a calculator telling them where they have to come out at the end of the day.

Chairman STARK. That is always simpler, I agree. That may be the answer. What about the hospitals? Is it going to be simpler, five or six payment structures?

Mr. DAVIDSON. You talked earlier in the hearing today about managed care.

Chairman STARK. I am talking now about structure.

Mr. DAVIDSON. This is an important response to your question in terms of the debate about managed care. Most of the managed care in this country is point of service cost control and things really aren't managed as such with somebody in charge of your care focusing on medical outcomes, ultimately changing your health status and all the rest.

When we talk about developing new delivery systems, they are different than the kinds of things that are necessarily embodied in the Clinton plan and that is that we think they have to be—community-based, community-owned, a community-based accountability system that looks at performance standards.

Chairman STARK. I hear you. If you have five different plans in any community where your members are operating, how can that simplify your admission procedures and procedures under which you discharge patients? You know you are going to get paid, procedures under which you allocate care to patients. Is there anything in that that makes it more simple than what you are doing today?

Mr. DAVIDSON. Let's take a for instance. Any given day in a hospital today there are 150 different utilization review forms being used even in nursing here.

Chairman STARK. And there is no change in the President's plan from that?

Mr. DAVIDSON. I think we will see a major restructuring of all of that. I think we are going to see a major consolidation of insurance, ultimately with an alignment with plans. We are going to have fewer players. You have an opportunity to establish standards of performance and Federal guidelines.

Today we can't get the insurance companies to agree on one form versus another so we get whipsawed in that process.

Chairman STARK. Do you think five insurance companies will survive?

Mr. DAVIDSON. I don't know what the number will be. It will probably be 150 by the end of the decade for purposes of conversation.

Chairman STARK. That isn't a very good conversation. Then you have still got your 150 plans. What does that simplify for you?

Mr. DAVIDSON. But in terms of their market penetration around the country you would have that consolidated pretty dramatically and you could establish Federal guidelines to develop some uniformity here. We don't have uniformity.

Chairman STARK. What did you say? Federal guidelines? Shame on you. You believe in term limits for association executives? Federal guidelines? Mr. Grandy.

Mr. GRANDY. Thank you, Mr. Chairman. Before I left the committee when the chairman was talking to the last panel, he was making a fairly convincing argument about the cost savings that have been achieved through Medicare for the last 10 years, and numerically the facts are on his side. If cost containment were the only goal in health care reform I would say this would be a fairly easy lift for this committee and the Budget Committee, but the whole question here is value, and that is a question of cost.

That is a function of cost plus access plus quality. Mr. Davidson, I would assume your association has already run the numbers on what the \$56 million in Medicare cuts did to your association members, particularly in manpower shortage areas such as rural and inner cities and are also now crunching the numbers on a prospective 125 billion dollars' worth of cuts.

The Iowa Hospital Association figures show that the previous cut figures out to about \$763 per patient loss and that is before you even get to health care reform.

Can you comment? Because I know all of you on the panel have said any kind of health care reform should include Medicare. We know that there will be cuts in Medicare to help pay for access while maintaining quality. Knowing that, how do you incorporate Medicare into a national health strategy through a system of, let's say, penalties and incentives that does not I think at this point deceive the public into thinking we can have a whole brand-new health care system that is going to hold Medicare harmless and say there is no risk selection?

Mr. DAVIDSON. The important point I think that you make in raising the question, Congressman, is that you can't really reform a delivery system unless you have everybody in and to leave Medicare out in essence leaves out 30 percent of the patients that we treat and many of your communities may represent 50 percent of the patients.

Mr. GRANDY. I think the figure is 55 percent. I am looking at the data of the Iowa Hospital Association.

Mr. DAVIDSON. Combine that with Medicaid patients and you have a system where we continue to cut back on payment and the hospitals are expected to do more. They try to shift the costs, but there is nobody to shift them to. We think that as we move forward looking at these numbers and, of course, the number of \$124 billion from this point forward still keeps Medicare in the same program, so it means that 80 percent of the dollars out of that \$124 billion are going to come out of reduced payments to hospitals and we don't even change the way we run the Medicare program.

We say you have got to start with the Medicare change. It should be done on the basis of incentives, because I think all of us understand the politics of how we may quickly frighten senior citizens that any kind of a change will be something that they can't tolerate. We have to demonstrate that there are opportunities in change, and instead of just expanding new benefits for everyone, we have to think about expansion of benefits for those who enroll in new organized delivery systems or reduction of copays and deductibles.

Mr. GRANDY. That leads me to, and this is a loaded question because I want to refer to the bill Mr. Cooper and I introduced yester-

day—we don't fully embrace a quantum change in Medicare. Contrary to the administration, which sweetens the pot for Medicare, I think, as kind of a nostrum for the costs that will come out of the program, we do provide an incentive for Medicare beneficiaries to buy out and buy into accountable health plans, the idea being that they could then access a prescription drug benefit.

Is that the kind of incentive that you think health care reform ought to encompass and if so, how do we expand on that to achieve the goal we are trying to achieve?

Mr. DAVIDSON. We certainly think you have to have universal access as well, and at the same time be moving the Medicare beneficiaries parallel to the expansion to coverage for the 37 million uninsured Americans.

Mr. GRANDY. Does that include, by the way, probably moving more people from fee-for-service into managed care models?

Mr. DAVIDSON. Organized delivery systems, yes. Organized delivery systems can still have fee-for-service.

Mr. GRANDY. I understand. But it does involve substantive change in thinking of the Medicare beneficiary population now.

Mr. DAVIDSON. We think we should be moving Medicare to a capitated payment system, as well.

Mr. GRANDY. Do you have any kind of preliminary judgment on a more market-driven managed competition system similar to what we introduced yesterday? I don't know if the AHA has taken a position on that or not. This is closer, of course, to the original Jackson Hole market driven system that is really more competition than management, as opposed to the Clinton plan, which I think is more management than competition.

Mr. DAVIDSON. We would say that our focus is more on collaboration than—we talk about managed competition. We think the focus ought to be on managed collaboration. If you get people to work together—this is part of what is wrong with our system. Most of us don't have anybody in charge of our care. We make decisions about what plan to get into, pick our own specialists. There is very little coordination in many cases, and so the focus ought to be on collaboration among the players to move people to the right settings, to help guide them through the system, to give them some advice as opposed to just competing on the basis of price. That goes back to your point of value.

We don't think this whole issue is a price question. We can keep spending a lot of money and not improve the outcomes.

Mr. GRANDY. We have. That is the system. If we do nothing we can be guaranteed of that outcome.

Mr. DAVIDSON. So we think you do have to focus on the collaborative initiatives.

Mr. GRANDY. You are talking about more than antitrust reforms. You are talking about markets as well, right; and health plans being offered competitively.

Mr. DAVIDSON. But with a local orientation. Our concern is that in these health alliances, as we move in that direction, we have protections, that they don't become fly-by-night insurance mechanisms run out of tall buildings in New York with computers and discount contracts. We think the key to the future is what you do in every community, forcing people or giving them incentives to

work together—doctors, long-term care institutions, public health agencies employers, insurers—we haven't had that going on in our community over the past decade because we were rewarded for a different behavior. So we think you have got to restructure the incentives to change everyone's behavior, including individual responsibility, as well, and I think your proposal starts to take things in that direction.

We would just wish that you would move to universal access in a quicker way and ultimately get Medicare in there in a faster way, as well.

Mr. GRANDY. Well, that is on the table. I guess the reason for not doing it is a kind of fiscal caution that comes with trying to get everybody in too fast as a price everybody can afford and that is something the administration is dealing with as well. So if we can find a way to split that difference, we can up the timetable.

Mr. DAVIDSON. We would be happy to work with you on that.

Mr. GRANDY. Thank you. Thank you, Mr. Chairman.

Chairman STARK. Who is next here. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman. I wanted to get back to the question of where we are going to find the resources, money, call it what you will, to expand access, so to speak, to everyone, and by expanding access to everyone let me clarify.

I am of the opinion that everyone in this country has access to the system today. They may not get the same service that everybody else gets, but I don't know of anybody who is dying on the street not getting health care. People get health care. They may not pay for it and the hospital has to shift those costs to the people who can pay, but, generally speaking, I think everybody has access to the health care system.

They are not insured, but they have access. What you are talking about is insuring that everybody has insurance, that everybody is going to be able to pay for the access that they get. I see you shaking your head. You think there are people dying on the streets that don't have access?

Mr. DAVIDSON. If I led you to that conclusion, I want to correct that conclusion. Not all Americans have access to health care. We take care of them in emergencies, but there are millions of people who defer any treatment because they don't have an ability to even present themselves or they don't want to be dehumanized by asking them the first typical question, which is how do you plan to pay for the care, because we have to do that.

On the one hand we do take care of people at the point of emergency, but there are a lot of people who aren't getting care because they don't have any health insurance. The part I was nodding on is that we can provide all Americans with health insurance and they still may not have access. Poor people have a Medicaid card in the Mississippi Delta, but they may not have access to anything. Having health insurance as a plastic card doesn't necessarily get you anything.

Part of what we are saying is that it is essential that we put together organized delivery systems in communities with responsibility for the people in the communities and that we assume some risks for taking care of them. Then we will reach out and really as-

sure "access." And we haven't had those kinds of incentives at this point in our history.

Mr. MCCRERY. What you are saying, I think, is that we need to come up with a better way to deliver health care to everybody in the country so that everybody gets quality health care in this country; is that generally correct?

Mr. DAVIDSON. That is exactly what we are saying.

Mr. MCCRERY. If everybody is not today getting quality health care then it seems to me there is going to be a cost associated with delivering quality health care to all those people who are not now getting it. Is that correct?

Mr. DAVIDSON. I certainly agree with that.

Mr. MCCRERY. Then where are we going to get the resources to provide those people with the quality health care that they are not getting today?

Mr. DAVIDSON. Well, there are two kinds of responses. Over time we will have an ability to deliver what it is that we do today much more efficiently than we now do if you ultimately put together community-based organizations with greater accountability and oversight. The other response is, if we determine that we want to have universal access and we are really serious about that and committed, then we are going to have to face tough choices.

One choice this committee is being faced with is whether to use an employer mandate to ensure that those people who are working who don't have health insurance will get it. We are looking at sin taxes and I think we can begin to look at a lot of things that are options for financing. We can look at new kinds of copays and deductibles in terms of looking at people on the basis of their income.

The President's proposal is calling for the expansion of care to retirees. There is a serious question about whether we could afford that or whether that ought to be income adjusted. It seems to me there are a lot of ways to turn the knobs, but the most important question is what is our commitment to achieving the goal of universal access? If we don't have a commitment to that then we won't find new ways to finance it.

Mr. MCCRERY. The bottom line is it will take some financing and Ms. Johnson, your association supports the Clinton health care plan so maybe you can explain to me what the previous panel wasn't able to explain, how the Clinton plan is going to cut Medicare \$124 billion, Medicaid \$114 billion, cut the deficit by \$91 billion, and provide universal access to everybody in this country defined, I think, as Mr. Davidson defines it, quality health care—I will go further and say a modicum of health care for everybody that is basically the same. How is that going to happen?

Ms. GWENDOLYN JOHNSON. I am not sure I can completely answer that question, but I think you need to start with the fact that the Clinton plan changes the health care system from an illness model to a wellness model. One of the things that the Clinton plan proposes is that we reach people through the use of primary and preventive care before they encounter expensive health problems.

I think certainly looking at those things that contribute to some of the major health problems, such as alcohol and tobacco, and in-

creasing those excise taxes would be one very appropriate funding mechanism.

I think the strong focus on the use of cost-effective providers, changing the focus from illness to wellness so that there is less cost involved in taking care of people before they become extremely ill will go a long way in terms of making a difference, in terms of financing. Again, I think the whole issue of access is very, very important because now the extreme costs that we are seeing are associated with that lack of universal access and the fact that people are very ill when they enter the hospital setting.

Dr. TODD. If I could, Congressman, look within the system. None of us at this table are qualified to sit and crunch the numbers, but we are qualified to look and see what delayed care costs this country in terms of people coming late to receive their care. If we could have more emphasis on prevention, immunization, we might well see some savings there.

The profession liability issue hasn't even been touched in terms of savings. There are tremendous savings to be gained there, the issue of overbearing regulation that needs to be reduced and most importantly the issue of economic discipline that says everybody ought to suffer the consequences or benefits of their health care decisions—and we know when patients are asked to contribute some degree of a copayment at the time of service, health care expenditures can be reduced without affecting the health of that population. That has been demonstrated. So there are many things within the system and depending upon how far the reform goes will help you decide how much savings you can get from those.

Mr. MCCRERY. I am certainly hopeful that we will get huge savings from preventive care, but I am rather skeptical of that. We are going to get some immediate benefit, but what of the long term? Eventually those people are going to get real sick and require care. I am not sure about the long-term picture that you are talking about. Perhaps immediately you will see savings, but I can't imagine that it is going to over the long haul save that money in the universe of the system.

I just want us to be honest about where we are going and it seems to me that many people who come before this committee and the administration are saying basically we want a health care system that delivers the same health care to everybody, an egalitarian system of health care. If that is the case, why don't we just do a single payer system, just tax everybody and deliver the same health care to everybody? Why jump through all these hoops with managed competition, whatever fancy words you used, Mr. Davidson, to say managed care.

Give the same health care to everybody and the fairest, easiest way to do that is just to tax everybody, send them into the same system, deliver the same health care to everybody, and you get paid the same for every procedure for every person, no matter who they are, where they come from.

Dr. TODD. If you do that, the quality of health care doesn't continue to increase. You know the successes of the American health care system in many respects has been based upon the professional competition that has been going on between facilities and centers

and physicians and hospitals. It is that competition that keeps progress moving.

If you go to a single payer where the rates are determined, what impetus is their for innovation? There is none.

Mr. McCRERY. I don't know but everybody gets the same care and that seems to me to be what you all are saying, everybody deserves the same care, so let's just do it.

Mr. DAVIDSON. Everyone deserves equal access to some kind of a minimum set of health insurance benefits and we all know that the quality of the care will vary geographically and by community and so forth. If there is something egalitarian, here it is, that all Americans ought to have universal access. And I think when you get past that, the changes will be striking in different parts of the United States based upon capability, and I think we will always reserve an individual's right to something other than what may be provided in any kind of a basic benefit plan.

I think we found that out in the Nations that have some kind of national health insurance.

Mr. McCRERY. You talked a little bit about utilization and how the Medicare system, as it currently operates, encourages overutilization. Would you expand on that a little bit? What do you mean by that?

Mr. DAVIDSON. In my remarks I was making reference to the forecast of reductions in the Medicare program without changing the way the Medicare program functions in terms of the financial rewards. In other words, the payment system is still on a per admission, per physician office visit which tends to provide incentives to drive up volumes not because there is malice, but that is because they are what the incentives are. They are perverse incentives.

And what we are suggesting is, if you are on some kind of fixed payment arrangement you will have a different incentive; that is, to prevent expensive hospitalization if it is preventable, to ensure that we have appropriate levels of physician visits, but only what is necessary, and that there are alternatives to treating patients. So it is back to delivery system changes that can, in fact, deliver that care better.

Our system rewards consuming more units of service. It finances the care from a lot of specialists.

Mr. McCRERY. How would you change that?

Mr. DAVIDSON. I am suggesting that we have an organized delivery system with fixed levels of payment where there is coordination within the hospital, if you are even admitted to the hospital, where someone is the gatekeeper and follows your care and consults with you and coordinates. We think that could be a lot more efficient than what we have now.

Dr. TODD. It would be nice if it could be that simple. But there are no benign incentives and, yes, you can look at fee-for-service and say it tends to be inflationary. We can look at managed care or capitation and say it tends to skimp on care. Neither one may be true, both may be true, but in a competitive system we ought to be providing information to the persons who are going to be using these systems as to the pros and cons and the costs involved and let them make the decision as to where they wish to receive their care.

Mr. McCRERY. Is that what you meant, Mr. Davidson, that to change the incentives of Medicare will just capitate it?

Mr. DAVIDSON. Yes, sir.

Mr. McCRERY. Thank you.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman. Dr. Todd, I understand in response to a previous question you did have something nice to say about the Canadian model. I certainly favor an American health care system and want to see us build upon the current system. However, I am very troubled by a sentence in your formal statement.

Let me just read it and ask you a question about it. You say, "Nowhere in the world in any kind of system that delivers any service or good to anyone have such spending controls ever worked," referring to global budgeting, et cetera. Did you mean to imply that most countries do not use some form of global budgeting in their health care system?

There are some very fine systems around the world. You weren't trying to infer that global budgeting is inconsistent with a quality health care system?

Dr. TODD. Global budgeting tends to fix in place the inequities and the shortcomings of the system that is already there with continued ratcheting down, which is inevitable as technology increases, population increases, expenditures tend to go up. But look around the world today. Canada is in the process of reevaluating its system, Sweden is in the process of reevaluating its system and Germany is in the process of reevaluating its system and they are all tending to move toward privatization rather than more government intervention. We don't have a good model.

Mr. CARDIN. But each one of those systems has some form of finite resources that are in health care allocated through some method, some more structured than others, some more government-involved than others. In fact, I don't know of any other industrial nation that has a health care system that doesn't have some form of budget discipline to it, do you?

Dr. TODD. No, and we firmly believe that this system ought to have budget discipline to it also, but it ought not to be tied to some arbitrary level of spending. It ought to be tied to appropriate care being given in appropriate settings to patients who need it.

Mr. CARDIN. We are in agreement on that point. I wanted to make sure that we had that on the record. You are not testifying against budget discipline, but a rigid system that could compromise the services being given throughout the regions of our country. That is a better way of framing that concern.

Dr. TODD. That is correct.

Mr. CARDIN. Mr. Davidson, I understand from Sean that you did respond and protect Maryland's system quite well. If I understand from your formal comments, you think the President's package would be strengthened if Medicare were part of the rules that apply to all the other reimbursements.

Mr. DAVIDSON. The whole notion of delivery system reform as a way to move will be improved by including Medicare; keeping Medicare on the current fee-for-service arrangement has the old incentives and we are trying to move the rest of the system to a system

designed to respond to different incentives and ultimately that becomes self-defeating. If you really want to change the way you deliver health services in this country by getting people into integrated financing and delivery systems, you can't leave senior citizens out, and that is the point.

We think that the Medicare program could run a lot more efficiently than it runs now and that it ought to be included in reform. That is not to say that you have to buy care through the alliances and all the rest. Medicare could be its own alliance. There are a lot of ways to look at that. But the fact is that there ought to be incentives to move Medicare beneficiaries into integrated delivery systems.

Mr. CARDIN. You are familiar with how hospitals have organized around the Nation. Would it be easier if Medicare were subject to the same set of rules, rather than having a separate set of rules, if you are trying to work within a finite amount of resources that are available to deliver hospital care in a community?

Is it more difficult having a separate set of rules for Medicare or is it easier, knowing what Medicare reimbursements are going to be, if you are trying to put together a system locally to deal with hospital costs.

Mr. DAVIDSON. It is more complicated. If you are trying to move to a new world and you are still working in a system that is in the old world and is going to continue to be there, that complicates your ability to achieve this new world objective, absolutely.

Mr. CARDIN. Thank you. Mr. Chairman, I will stay within my 5 minutes.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON of Connecticut. Thank you, Mr. Chairman. I am sorry I missed your presentations, but I have a couple of questions I want to ask you. There is so much agreement on what we are trying to achieve, but the means are very controversial and there is a lot of concern that some of the means in the President's bill, actually are totally counterproductive in terms of the goals.

I, too, Mr. Davidson am very concerned with and very committed to community-based health care. If reform doesn't mean that communities get more involved in planning that network of care that will really guarantee a coordinated system and the kind of comprehensive care that we are all hoping we get out of reform, then we will have failed.

One of the reasons I am so concerned about the President's program is I think giant health alliances and global budgets and premium fixing and that kind of mechanism that we like in Washington is actually very antagonistic to the people in the real world doing what they need to do for their health.

A perfect example is the clean air regulations. We are in the bizarre position of forcing people to buy different kinds of fuels, to dump their cars, to do all kinds of things not because they are in an area that produces a lot of pollution, but because some other area near them does so. So Washington has a hard time actually assuring that changes take place in a way that are good for the individual Americans in our Nation and for the communities.

I would like to know from you, Mr. Davidson, what are the incentives that are most important to assuring that health care reform

does encourage community care networks as opposed to insurance companies driving the concept of care networks and, doctor, from your point of view what is going to really assure that the end result of reform is physicians working with other health professionals, physician assistants, nurse midwives, psychiatric social workers—what is going to assure that they are going to look at those things and create the kind of coordinated system of care that won't just assume, as we have in the past, that if you have a heart condition you must go to a cardiologist; if you have a headache you must go to a neurologist. So both are similar kinds of issues. How, from Washington, can we drive a health care reform initiative that will allow people and communities the power to assure that they get quality care at the lowest cost?

Mr. DAVIDSON. It seems to me you have to set up a system where Washington provides the incentives to the extent they can.

Mrs. JOHNSON of Connecticut. What are the key incentives?

Mr. DAVIDSON. First, to move to capitated payment, capitated payment arrangements.

Mrs. JOHNSON of Connecticut. What is the evidence that capitated payment alone is better than fee-for-service? Aren't we seeing a great variety of systems that are cost-effective and do we really want to define from Washington that capitation is the right answer?

Mr. DAVIDSON. Capitation is a way to provide the incentives that ultimately put people together in integrated systems at the local level. There is evidence that shows when you begin to evaluate managed care that the current form of managed care around the country by and large is point of service cost control, not really integrated delivery systems.

Research shows that you get much more effective results with closely integrated delivery systems and we ought to encourage their development at the community level because then following that you can build in mechanisms for public accountability, and we are afraid that if you don't have local accountability things will get lost.

Mrs. JOHNSON of Connecticut. That is very interesting because I have maintained that the issue of limiting tax deductibility so you focus the competition between systems on cost-effective care rather than the government deciding that capitation is the payment system that works is not only safer but more powerful. I hope we can talk about that—

Mr. DAVIDSON. Certainly, but that is an incentive to begin to move you pretty quickly in that direction. Also, if you have a premium structure that ultimately encourages people to move into integrated delivery systems there is some incentive.

In other words, if you begin to look at all the ways that you structure these things, you can build an incentive system. You've got to have insurance market reform that ultimately will eliminate the skimming and we have talked about that. There seems to be agreement on that one at this point. It seems to me when you do that you then set up a set of incentives that will take you in that direction as well.

Mrs. JOHNSON of Connecticut. Of the things you have mentioned, having tax deductibility limited to, say, the average of the five low-

est cost plans gives you premiums that drive cost-effective systems and integrated care without limiting you as a capitated payment would. A capitated payment set from Washington isn't going to be a lot different than a premium set from Washington. I look forward to further dialog—

Mr. DAVIDSON. You will see a lot of local negotiation. This takes to the question of the alliance and how big it ought to be. We think they ought to be kept small at the outset and see how they work. Let's not deny people the right to ultimately negotiate some agreements locally between employers and organized delivery systems. That is what is going on across the country now. There is quite a bit of activity. We ought to encourage that and stimulate it.

Mrs. JOHNSON of Connecticut. Should we give local communities the right to apply for the amount of money associated with their Medicaid-eligible population and give them the right to plan a community response to universal access using those Federal dollars?

Mr. DAVIDSON. I think we ought to encourage all kinds of innovative approaches to ultimately move Medicaid and Medicare beneficiaries into organized delivery systems—we can do that today. We don't have to wait for anybody to pass a new law.

Mrs. JOHNSON of Connecticut. I tried it this year in the committee, but it didn't work.

Mr. DAVIDSON. We have been encouraging the Health Care Financing Administration to begin to move in that direction. I think the administrator is convinced that that is an initiative they want to take, so before we even enact anything we can begin to make those things happen.

Dr. TODD. Let me, if I may give, the AMA's answer to the basic question you asked, can this be controlled by Washington. Our answer is absolutely, no, it cannot. Health care, like politics, is local. It is given one doctor and one patient at a time. One size does not fit all.

We would say that in our order of priority we have to guarantee access. We have to guarantee quality. We ought to guarantee choice, because after all that is what makes individuals differ from geographic area to geographic area and there has to be economic discipline, but everybody has to participate in that economic discipline, not just the insurance companies or the providers.

Last, you mentioned another subject which I think is important in terms of how well we are using our mid-level practitioners. We probably haven't done a good job at that in the past. We should be entering the age of cooperation where there are possibilities for groups to join together that have not in the past and in the process effect continuing savings and efficiency in the system.

Mrs. JOHNSON of Connecticut. Dr. Todd, how important is malpractice reform to using physician assistants to internists referring less often?

Dr. TODD. It is probably one of the most important not only to doctors but to patients. The doctor-patient relationship is suffering as a consequence of professional liability threat all the time. Patients in some areas aren't able to get the services locally they might need because physicians are withdrawing from providing some of the high risk procedures. When you see the number of physicians that are being sued year after year, you know they are not

all that incompetent. You know they are not all that careless. It is the system.

To add to your concerns about where savings come we estimate from defensive medicine that we could probably save in the neighborhood of \$15 billion a year, but more importantly an independent agency did a study and they concluded the savings could be as much as \$36 billion over a 5-year period. So professional liability tort reform is essential, particularly if you expect physicians in this country to only provide necessary rational care. They cannot take the risk of using clinical judgment until they have some idea they are going to be protected.

Mrs. JOHNSON of Connecticut. In other words, it underlies the success of the other reforms?

Dr. TODD. Absolutely.

Mrs. JOHNSON of Connecticut. Thank you. I thank the panel for your discussion today.

Chairman STARK. This is a little off the topic, but it is something I have discussed with Mr. Davidson and Dr. Todd separately. On the off chance that these plans which suggest that this can all be accomplished without any revenues aren't successful in finding this medical care fair who is going to put the solution under our pillow? We have been talking about a variety of ways to raise the money and, frankly, I don't think there is anything new.

The real issue is going to be how we are going to sell whatever revenue raiser we come up with, whether it is a mandate on business—somebody will call it a tax—my opponent, if nobody else does it. I have often suggested, and you might comment on this, the idea of what would be a sales tax, a gross receipts tax or some other kind of charge on all providers, the proceeds of which would go into a trust fund and be used only for uninsured low income.

Some of your members, Dick, do that. New Jersey and maybe Florida—I am not sure whether they do it happily, but it is not unknown to the hospital industry. Somebody indicated there was a State that tried it with physicians. I will stay silent as to the amount. Say 10 percent of \$140 billion would pay for it in a New York minute, but I don't think that we are going to get anywhere near that. The reason that is good is because the public, frankly, would be confused. They will think the rich hospitals, the rich doctors, the rich pharmaceutical companies are getting hit and we are not. We know that is not true, they would ultimately pay some, whatever their share of the payment the President wants them to bear would be. Is that an area in which we could negotiate?

Mr. DAVIDSON. Mr. Chairman, we can search every which way from Sunday to find a new base for taxing and if you talk about taxing hospitals ultimately the public pays.

Chairman STARK. But you get it all back. You understand that.

Mr. DAVIDSON. I don't know that to be so.

Chairman STARK. I just told you. It goes into a medical trust fund. It can only be spent for medical care. Basically it would come back in the form of, I would presume, hospitals helping to eliminate uncompensated care and bad debt.

Mr. DAVIDSON. The question has been raised before, whether, in fact, there is a windfall, that if you ultimately have universal access, is there a windfall to hospitals.

Chairman STARK. I just asked if this was a——

Mr. DAVIDSON. The fact of the matter is that if we are paying for care that we didn't pay for before, most of that care is provided by institutions that have very low or negative margins. So ultimately if you compensate them and think somehow there is a windfall and ultimately we can recoup it, it doesn't play out that way—it really doesn't.

Ultimately, the public is going to pay for it in one form or another. It is a legitimate public policy question to raise, Mr. Chairman. We would oppose it.

Chairman STARK. It isn't a public policy. It is a political problem in how do you sell a tax to get enough votes to do it? The only thing that has any interest to me in this idea is that it might be a way to get 218 votes in the House and 50 votes in the Senate to raise \$20, \$30, \$40, \$50 billion, which would all be spent in medical care. The savings that we would be collecting largely would go to General Motors, General Electric—those companies that have been paying high generous benefits over the years stand to be the biggest savers in most of these plans.

It is hard to get it back from them. There is a good argument that maybe they have been paying all these years, they should ask for it back. New Jersey and Florida do it.

Mr. DAVIDSON. We have had it happen in ways to subsidize the Medicaid program. These were practical actions for survival.

Chairman STARK. Is that something that would be an absolute anathema to the hospital industry?

Mr. DAVIDSON. I don't think you can consider it in isolation. That is the problem. We are talking about revenue caps on the private side down the road and then you begin to couple that notion with a taxation thing. I don't think you can talk about any of these ideas by themselves. I think you have to talk about them in the broad context of how do we get from here to there. And I am suggesting to you that at this point we would oppose it, but it is a legitimate policy question.

Chairman STARK. What would you support?

Mr. DAVIDSON. I suggest that if we have all of the pieces on the table—they are not on the table yet. I reverse it and say are you willing to say that we will not have a premium cap as proposed by Mr. Clinton?

Chairman STARK. If that were my choice certainly not.

Mr. DAVIDSON. Do you have the votes to——

Chairman STARK. I wouldn't vote for a premium cap. I think it is nutty. But I am 1 of 218 needed. My point is I am willing to commit to certain parts of the piece. If everybody has to wait until this program with infinite variables that are at least three or four dimensional is in focus before they will commit to any part of it, then you are going to wait an awful long time for the plan.

We will at some point have to make certain decisions and I was asking for your assistance today insofar as you are able to help us. To comment on one small part of the plan, how do you think the physicians, would we have a Canadian strike?

Dr. TODD. Physicians wouldn't strike, but a provider tax is really just a tax on sick people. Eventually it is going to end up coming out of the pockets of those least able to afford it. You heard earlier

today that 5 percent of the population consume about 50 percent of the health care services in this country. If you run a provider tax you are taxing about 5 percent of the population.

Chairman STARK. However if you have a broad-based tax you are taxing everybody for that same 5 percent. And because we mostly pay for our medical care through insurance, I suppose 70 or 80 percent of it, our payment now is spread so that in fact if there was a tax on doctors, it would be shared by a far broader segment of the population than just those who are sick because we now, for the most part, spread that cost broadly across the population. So it would not just be a tax on that 5 percent, it might be a tax on only 70 or 80 percent because those who are uninsured now aren't contributing.

Dr. TODD. That may be true, but you are singling out for taxation a very select portion of the population.

Chairman STARK. Yes, a very rich portion, the highest paid profession in the country, the richest industrial section in the pharmaceutical area, and very, very substantial not-for-profit institutions who run a lot of change through their—all I am saying is that every penny that we single those people out to contribute comes back to them. Not in the same form—but you could look at it as a recapturing the cost shifting.

Dr. TODD. If indeed the cost shifting disappears, that may be a different matter. What you just said is true on the average, but there are physicians in portions of this country for whom a provider tax would be an additional burden that they are not being reimbursed at the level they deserve or the amount of time and energy they devote to their profession.

When you say it is the highest paid profession——

Chairman STARK. It is the highest paid profession in the United States today bar none, and that is a fact.

Dr. TODD. I just want to make the point that you are talking about averages though.

Chairman STARK. You want to get into specifics about high paid people in the medical profession outside that, bring that average up? We will talk about \$700,000 or \$800,000 in salaries and guys who get fees——

Dr. TODD. Some of that wouldn't be there if the Federal Trade Commission would give us the ability to do some of the things we need to do and that is why we are asking in any health system reform for some antitrust relief.

Chairman STARK. No question you have that. I will vote for it.

Ms. GWENDOLYN JOHNSON. You were talking specifically about highly paid providers. In one State in the United States, in Kentucky I believe, they are proposing to tax staff nurses in that manner and that is not an income that they are going to see coming back to them. It would be a question of how you define that kind of a provider tax, based on what we know is going on in some of the States in the country.

Chairman STARK. I would have the same. Many nurses make more than pediatricians. Primary doctors in my area are complaining the nurse gets \$76 per house call and he only gets \$26 per house call. But that you can fight out among yourselves.

My point is that this was a mere suggestion that once we have tackled the cigarette industry or the tobacco industry and whom-ever else we can hit for some contributions whether the providers might find it enough in their own self-interest to do this as a way and all of this is a way to reapportion some of the money that we are collecting from the high paying people, we can then forget about the high earners. They are taking a big chunk out of those fee-for-service physicians that pay more than say an HMO physicians on a salary, take some of that off the top.

Very few doctors get their charges. I am saying no more bad debts, no more charity care, so that it is conceivable that not all of a gross receipts tax would be lost, but indeed some of it would come back in increased gross income. The same would be true for hospitals and pharmaceuticals. They would sell more pharmaceuticals. Whether they think it would all come out even is something you will have to calculate.

To me if you thought you saw a plan that you like and we had to raise \$30 billion, you would be hard-pressed to find a tax. It is something I hope that you all might consider.

Dr. TODD. If you eliminated bad debt and the cost shifting you would see stabilization in prices that would perhaps be just as valuable to you as a recoupment tax.

Chairman STARK. We are short of dough. We could have the best plan we all agreed to and come up short, say \$50 billion a year, and that is going to be difficult politically. I am saying to you rather than see a good plan fail, one that you might really like for want of \$50 billion in taxes because we can't pass one—

Mr. DAVIDSON. So we will adjust those proposed Medicare cuts and we will eliminate that private sector cap—that is the nature of the discussion that you would have if you were getting into this and had all the pieces on the table. You are a good salesman, Mr. Chairman.

Chairman STARK. I am not obviously selling you guys much, but my guess is that the hospitals aren't going to help us much anyway, so that is a fair way to end.

Mr. DAVIDSON. You know you don't believe that.

Chairman STARK. Oh, yes I do. Thank you very much.

Mr. MCCRERY. One point that I want to make, Mr. Davidson made with respect to the hospitals. He said if you tax the hospitals, it is really the public that ultimately pays.

Well, in fact, a tax on employers through an employer mandate is going to be paid ultimately by the public, either in the form of higher prices for products they buy or in the form of lower wages to compensate for the increased cost to the employer of buying the insurance, so I am glad you made that point.

It should be made clear to the public that they are going to pay one way or another for increased services.

Dr. Todd, you mentioned briefly in your list of things that could be done to squeeze costs out of the current system copayments and coinsurance. I would like for all of you to maybe elaborate on that a bit because in all the research that I have done on cost drivers in the system, that to me stands out as the most dramatic.

Mr. Davidson talked about incentives in the Medicare system for overutilization by the providers, but I would submit that the third

party payment system that is prevalent in this country—70 to 80 percent of all of us have somebody else paying our bill—is responsible for overutilization by individuals in this health care system.

Am I wrong? Can you back that up? Do you agree or disagree?

Dr. TODD. Yes, we can give you some objective information in that regard.

First, from the Physician Payment Review Commission, who began to study the effect of limiting the balanced billing and the level of increased utilization that that produced, a study done by the Rand Institute in California some years ago that showed if you placed a nondisabling deductible on a prospective patient, that you could reduce health care utilization by about 39 percent and not show any change in the overall health of that population, so that, you know, the economic consequences of health care decisions are important.

Chairman STARK. If you would excuse me, that same health care study showed that half of the care that was withheld was needed.

Dr. TODD. That was a different study, Mr. Stark. That study has been repeated using contemporary standards, and that figure is clearly in error.

That study was done based on indications that were used in, I think, 1987 based on 1989 standards, and that is not a fair comparison. A repeat study done by the academic health centers has shown that the unnecessary provision of services is somewhere 7 to 9 percent.

Mr. McCRERY. Mr. Davidson.

Mr. DAVIDSON. I would concur. I support the notion of individual responsibility, and that is part of what we have got to come to grips with. We all have to have shared responsibility, whether it be hospitals, doctors, individuals. In other words, there is no free lunch in getting to the objective of achieving universal access. There does have to be shared sacrifice, and that means for you and me as potential patients.

Mr. McCRERY. Does that mean we need higher copayments or co-insurance on Medicare?

Mr. DAVIDSON. I think we need to look at all those kinds of options that affect our behavior.

Dr. TODD. But we have to be sure that they are not disabling. They have to be at the right level so that they by themselves don't become an impediment to needed health care.

Mr. McCRERY. Don't discourage needed health care.

Mr. DAVIDSON. Just mechanically, copays are a lot easier to deal with than deductibles which you have to track in computer systems and all the rest, but it is important to think through that.

Ms. GWENDOLYN JOHNSON. Mr. McCrery, I would like to add my concern related to copayments that would go to areas such as prenatal care and immunizations. I think we should not implement into the system anything that would serve as a disincentive for those kinds of services to be provided. I think we need to be very careful, when we say that everyone has to pay in some kind of a way, to look at whether or not there will be true disincentives in areas where that care should be provided no matter what.

Mr. McCRERY. I agree. In fact, if you expanded the degree of responsibility on the individual for ordinary medical care, you could

build in greater incentives for preventive care like immunizations or prenatal care that would work perhaps better than the system we have today in which many insurance policies don't cover those things, and they cover a lot of other nuts and bolts stuff that people should be able to buy on their own.

Ms. GWENDOLYN JOHNSON. I agree with you. The disincentives would be related to those areas of preventive care; and that is what we are very concerned about if they do start to institute copayments in those particular areas.

Mr. MCCRERY. Thank you all very much.

Thank you, Mr. Chairman.

Chairman STARK. Thank you. Thank the panel.

If there are no further comments, the hearing is adjourned.

[Whereupon, at 3:28 p.m., the committee was adjourned, to reconvene at 10:30 a.m., Thursday, October 21, 1993.]

PRESIDENT'S HEALTH CARE REFORM PROPOSALS: IMPACT ON PROVIDERS AND CONSUMERS

THURSDAY, OCTOBER 21, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:40 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

Chairman STARK. Good morning.

Today, the subcommittee continues its series of hearings on health reform with testimony from representatives of consumer groups.

I commend the President for his commitment to comprehensive reform and repeat our commitment to help him achieve goals that he so forcefully articulated in his address to the Nation a month ago.

There are many aspects of this plan which I support and believe this subcommittee could enact, with relatively minor adjustments. The proposals for insurance reform, administrative simplification, fraud and abuse, prescription drugs for seniors, perhaps, may fall into this category.

Of course, with an issue of this complexity, there are other aspects of the plan which may require modification.

I am concerned, for example, that the plan, as described, will not adequately address the needs of low-income and otherwise underserved health care consumers. The low-income subsidy proposal, which subsidizes premiums but not other cost-sharing requirements, would deny the poor a choice among health plans.

And we heard in the press over the weekend that that plan would not be an entitlement for the poor but would require subsequent appropriations, a feat which I think is beyond the ability of the legislative legerdemain of this committee.

Without modification, those policies would force those who rely upon subsidies into the least cost plan in an alliance area and, indeed, perhaps exacerbate the difference in quality between the least cost plans and others.

This problem for the less well-to-do will be exacerbated if health plans are permitted to exclude individuals from defined service areas or, as we used to say in the banking business and insurance business, "redlining."

I am sure that each member of this subcommittee has his or her own list of concerns. Each of those issues will have to be addressed and resolved as we proceed through the legislative process.

I hope our witnesses will work with the subcommittee as we examine the impact of the health reform plan on our respective constituencies.

As part of this discussion, we invite our witnesses to comment on the relative strengths and weaknesses of the President's plan relative to alternative health care reform plans that have been introduced this session or discussed generally in the press.

Before proceeding with our testimony, I would like to welcome our ranking member, Mr. Thomas, and recognize him for an opening statement.

Mr. THOMAS. Mr. Chairman, let's just begin the hearing. We have a lot of folks and a lot of hearings. And if I make an opening statement at every one of them, I will consume far more time than I should over the course of these hearings. So let's begin.

Mr. GRANDY. Mr. Chairman.

Chairman STARK. On the face of that, there is someone with the temerity to make an opening statement.

Mr. Grandy.

Mr. GRANDY. I make it reluctantly, only because Mr. Thomas has yielded his time and because I find my position on this committee being relegated to one of defense more than offense.

And let me just begin by reading from the daily White House report on health care reform, which applauds Carl Schram, who is the former head of the Health Insurance Association of America, chastising his former association for putting on reprehensible and irresponsible—I am quoting now—ads to trash the Clinton administration's proposal. The administration applauds him for being a constructive spokesperson.

Chairman STARK. Would the gentleman yield?

Mr. GRANDY. Yes.

Chairman STARK. When you give somebody a golden parachute, make sure one of the conditions are they don't trash the former employer before you can them.

Mr. GRANDY. Well, that leads me to my second point, Mr. Chairman.

Meanwhile, in a more dimly lit part of the White House, the ongoing operation to trash all the other details of all the other plans, rather than write the details of their own plan, is proceeding apace.

And at almost the same time, a letter went out to Members of Congress yesterday, signed by a group of 50 supposedly bipartisan and very broad-based associations—half of them unions, the rest consumer groups—basically tearing apart the Cooper-Grandy plan.

While I am flattered by their attention, I am somewhat appalled by their inaccuracy and want to bring to this committee's attention again that the ongoing hearings that we have had at this point have broken down into three categories:

We have had the Clinton speech, followed by the Clinton concert in front of all of the committees in the House and Senate, and now we are hearing the Clinton defense.

But we still have no Clinton plan, no details, no numbers. That is what we have.

Now there are at least three members of this committee that have authored, scored, and prepared plans, the details of which are now being taken apart.

I just hope that if we are going to continue to chew on each other, the one goal that we supposedly are all espousing but refuse to practice, bipartisanship, will not happen. And if that does not happen, neither will health care reform.

There is no way you are going to force feed a health plan the way a budget was force fed into this Congress. And I am loath to make this kind of statement at the outset of the debate, but I want all of the people, particularly those members on the panel today who signed this letter, to be forewarned. If you are ready to tear apart the Cooper-Grandy plan, you better come prepared and you better be able to defend the differences between the Cooper plan and the administration plan, one of which has been authored, the other which has been alluded to.

Thank you, Mr. Chairman.

Chairman STARK. If the gentleman would yield.

Mr. GRANDY. I graciously yield to my benevolent Chairman.

Chairman STARK. I would graciously associate myself with the gentleman's remarks in their entirety.

But I would qualify myself as prepared, able, and willing to debate the gentleman on the efficacy and effectiveness of the Cooper-Grandy plan. He may choose the time and the weapons.

Mr. GRANDY. Mr. Chairman, let the games begin.

Chairman STARK. For now we will proceed.

Mr. GRANDY. Mr. Chairman, can I just reclaim my time for just a moment?

You and I both know we have our philosophical differences on the route health care should take, but we have at least done the work expected of us.

Your plan is written and scored. Our plan is written and scored. We, when we engage, will have all of our missiles and all of our silos, and they will have warheads.

Chairman STARK. The gentleman is absolutely correct.

Mr. Kleczka, then Mr. Thomas.

Mr. KLECZKA. Mr. Chairman, let me also address some comments to our panel today.

By virtue of your being here, you do not lose any of your first amendment rights. So when your turn is called, say what you want for or against any plan. And please don't be constrained.

Thank you very much.

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Mr. Chairman, briefly, I understand the frustration of my colleague; and I guess you and I have both been characterized as being somewhat frustrated, primarily because the administration, back on September 22, had the President address a joint session of Congress in terms of describing his plan. Now, here we are, literally 1 month later with no plan.

Hopefully, next month we can enter into the specific discussions that my friend and colleague from Iowa desires. Then we can get away from this silly little thing about what we think a new plan is going to deliver and look at the particulars.

Unfortunately, we are laboring under a situation in which the White House—which Roosevelt described as a bully pulpit, and which President Clinton is clearly pointing out with the First Lady—is, in transmitting a general propaganda position, in favor of assumptions versus our dealing with specifics.

It is very frustrating for all of us. I share the frustrations and hope they will be short-lived. So when someone does make a negative comment about a plan that is out there, they do need to be prepared to defend the plan that is not out there or you can't make the negative comments.

Thank you.

Chairman STARK. Thank you.

If there are no other statements, we will get to the heart of the matter. Our first panel represents senior citizens' groups, the principal constituency of this committee over these past 28 years.

I am happy to welcome Judith Brown, the chair of the board of directors of the American Association of Retired Persons; Dianna Porter, public policy director of the Older Women's League; and Martha McSteen, who is president of the National Committee to Preserve Social Security and Medicare.

We welcome you all to the subcommittee.

And as for all the witnesses today, your complete written statements will be part of the record of this hearing, for which, at this point, I ask unanimous consent.

And without objection, that will be the case.

In addition, I would ask that all witnesses limit their oral statements to 5 minutes. They may summarize or expand on their written statements, and this will allow the members adequate time to explore particular issues of interest. And I know they are anxious to do that.

Please proceed, Ms. Brown, in any manner you choose.

STATEMENT OF JUDITH BROWN, CHAIR, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS

Ms. BROWN. Thank you very much, Mr. Chairman. Good morning.

My name is Judy Brown, and I am the chair of the board of AARP. As an organization representing over 33 million older Americans, AARP has had a longstanding interest in comprehensive health care reform.

We commend both the President and Mrs. Clinton and Members of Congress in both parties for a commitment to addressing this issue now.

Enactment of reform will require not just bipartisan cooperation but bipartisan leadership. AARP will not support or oppose the President's plan or any plan blindly.

The day after the President's speech, we began the latest round of hearings across the Nation to ask our members what they think, adding to the thousands of hearings we have held over the past 3 years. We will carefully analyze the President's plan in terms of its effect on our members, their families, and the Nation.

I would like to focus my oral remarks on a few major areas. Financing and cost containment: We commend the President for establishing explicit financing for comprehensive reform and look for-

ward to an open discussion of the cost and financing assumptions and estimates. Close scrutiny of the numbers is critical because, if the proposed savings and revenues do not materialize, then important benefits such as prescription drugs and long-term care—benefits that are at the core of the older American's support for health care reform—will be reduced and/or the entire reform effort may be jeopardized.

Experience has shown that cost estimates only grow as the legislative process advances. We agree with two critical aspects of the President's proposal to curb health care costs, universal coverage, and systemwide cost containment.

Mr. Chairman, without systemwide cost containment and universal coverage, AARP will strongly oppose further Medicare cuts. The association will continue its assessment of the proposed cuts, which are very alarming on their face, as we examine the effectiveness of proposed savings in the private sector.

AARP generally supports the President's proposal to limit growth in health care premiums in the private sector. Between 1985 and 1991, per capita spending in Medicare, which has been subject to cost cutting, grew at a much lower, slower rate than per capita spending in the rest of the health care system.

The association supports the President's effort to build upon existing financing mechanisms, particularly the requirement that employers pay 80 percent of the premiums. Nevertheless, AARP believes that broader, more progressive, and more stable sources of revenue will be needed. AARP is particularly pleased that the President's proposal includes a modest start for home- and community-based care for persons of all ages and all incomes. Long-term care is essential to our members and critical to AARP support for any health care reform proposal.

However, we have several concerns. They include whether funding will be adequate for States to assure that all eligible beneficiaries receive needed services and whether broad State flexibility will lead to the kind of tremendous variation and fragmentation that exists in Medicaid.

And while AARP supports the plan's modest Medicaid improvements in nursing home insurance standards, millions would remain unprotected against enormous nursing home costs.

The future of Medicare: AARP agrees with the decision to retain Medicare as a separate program. Indeed, Medicare can be thought of as its own national health alliance. We are disappointed, however, that Medicare beneficiaries would not receive the same coverage as other Americans. We are very concerned about and would recommend extreme caution regarding States taking over Medicare's program.

In conclusion, Mr. Chairman, AARP commends the President and Members on both sides of the aisle who have brought health care reform to this point. We recognize that reform may need to be phased in over periods of years. Adjustments will need to be made, but we must have comprehensive health care reform, and we must have it now.

Thank you.

Chairman STARK. Thank you very much.

[The prepared statement follows:]

**TESTIMONY OF JUDITH BROWN, CHAIR
BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS**

Good morning. My name is Judith Brown. I am Chair of the Board of Directors of the American Association of Retired Persons (AARP). Thank you for the opportunity to testify today as the Subcommittee probes the public commitment to health care reform and reviews the President's plan.

As a membership organization of 33 million older Americans, AARP has a longstanding and profound interest in this debate. Roughly half of our members are between the ages of 50 and 64; the other half are over 65. Approximately one-third of our members are still in the workforce.

Over the past few years, we have listened closely to what our diverse membership and their families want in a health care system. Despite their differing circumstances, the vast majority of Americans, old and young, have stressed a need for broader protections against the high costs of health and long-term care.

One month ago the President stood before Congress and the American people and pledged his leadership in fixing our broken health care system. He called on members of both political parties to seize the "magic moment" of opportunity by enacting universal and comprehensive health care. AARP commends President Clinton for his bold and constructive plan for accomplishing reform. We also commend the First Lady, Congressional leaders in both parties, and this Subcommittee for a commitment to addressing this issue now. We believe that true reform must cover everyone, maintain high quality, make health care costs affordable, and include vital prescription drugs and long-term care.

Lessons From The Past

A great national debate has begun, a debate that will affect every family and that cuts across socioeconomic, cultural, and racial lines. Older Americans welcome the opportunity for Congress and the President to demonstrate not only that they are listening to the American people, but also that both parties can work together constructively toward much-needed change in our health care system. Before outlining the Association's views on the President's plan, and in light of the long memories of most AARP members, we find it useful to offer an historical perspective on today's health care debate.

Almost sixty years ago, President Roosevelt signed into law the landmark Social Security program. Social Security was a bold response to the growing crisis of insecurity among American families. Thirty years later the Medicare and Medicaid programs were enacted. Like Social Security, Medicare's protections are universal and its financing is broad based. Consequently, Medicare and Social Security are popular among all age groups. Medicaid, on the other hand, as a means-tested program that varies widely across the states, does not enjoy the same popular support. The flaws that characterize the Medicaid program today must be avoided in a reformed health care system.

Just five years ago, the Medicare Catastrophic Coverage Act was enacted and then repealed by Congress and the President. AARP learned some valuable lessons from that episode, lessons that we hope will serve us and policymakers well.

First, we learned that incremental gap-filling in the current health care system simply is not acceptable to the American people. Older Americans viewed the new Catastrophic benefits as too meager to warrant widespread support, particularly because long-term care was not included.

Second, we learned that financing for health benefits cannot be narrowly imposed on a small segment of the population. Medicare beneficiaries were required to pay 100% of the cost of the Catastrophic program, increasing the flat and income-related premiums to extraordinary levels.

Third, we discovered that estimates for financing the new benefits proved inadequate at many points along the way, requiring cutbacks in benefits before the bill was enacted.

Fourth, we found it unrealistic to front-load the "pain" of additional beneficiary payments without a corresponding "gain" in benefits. While most older Americans have shown great patience in their lives, asking them for a full downpayment well in advance of receiving benefits proved unacceptable.

Finally, we learned that the American people must clearly understand the benefits and costs of change in the health care system and that all of us need to listen and be prepared to respond knowledgeably to their concerns. After the Catastrophic bill was enacted, misinformation abounded and clear-cut answers to legitimate questions were in short supply. Since then, AARP has made a major effort to educate our members about the problems in the current health care system and to listen more attentively to our members' concerns and preferences. This time around, the challenge is much greater, and we simply must get it right.

AARP is deeply committed to comprehensive health care reform now. If reform must be phased in over a number of years because the financing is not adequate in the short term, then so be it. If mid-course adjustments are needed along the way -- and they will be -- then build in the means to determine them and carry them out. But it is imperative that Congress enact a comprehensive approach at the outset -- establish in legislation a "blueprint" for a reformed health care system -- not simply patch up spots pell-mell from year to year.

Key Elements of Health Care Reform

What does AARP mean by comprehensive reform? At a minimum comprehensive reform must provide:

- o A federal guarantee that all individuals have access to affordable, high-quality health and long-term care;
- o System-wide cost containment that eliminates cost-shifting and slows the explosive growth in health spending;
- o Comprehensive benefits that include prevention, physical and mental health care, prescription drugs, home and community-based care, and nursing home care;
- o Health delivery system reforms that increase access to care in underserved areas and reward efficient, high-quality care; and
- o Broad-based, fair and affordable financing, so that government, businesses, and individuals all pay their share and everyone is protected against the high costs of care.

AARP's proposal for comprehensive health care reform, "Health Care America," was developed with the extensive involvement of AARP members across the country. Its centerpiece is a strengthened and expanded Medicare program through which everyone would be eligible for a comprehensive, nationally mandated package of medical and long-term care benefits. Employers would be required to contribute to the cost of their workers' benefits, either through the expanded Medicare program or through private coverage. In addition to ensuring access, the system would continue to foster choice, diversity, and innovation in the delivery of health services. The system would be accountable to consumers through a new Federal Health Care Commission that would set spending targets and establish other rules.

AARP Views on the President's Plan

Now that the President's plan is before Congress and the American people, we have shifted our attention to reviewing its many details while using "Health Care America" as a guide. AARP will not support or oppose the President's plan blindly. The day after the President's speech, we began a series of field hearings across the country to ask our members what they think. We will carefully analyze the plan in terms of its effect on our members, their families, and the nation. We will assess its status at each step of the legislative process, and

work to improve it. As a start, we have already identified many promising features of the plan as well as some significant concerns.

System-Wide Cost Containment

Rapidly growing health care costs now rob our nation's economy, businesses, and families of the financial security which we all need to prosper in the future. And many families, including millions of families of older Americans, find it increasingly difficult to even see the future around the mounting health care bills on the kitchen table.

There is much in the President's proposals to curb health care costs with which we agree:

First, universal coverage must accompany cost controls if they are to be successful.

A reform proposal that fails to assure that everyone has coverage will only lead to another vicious round of cost-shifting between payers and between providers. With universal coverage, providers will know that they will receive adequate payment for their services. And families will be reassured that they can seek necessary care at the appropriate time without being turned away. Only with the security of universal coverage can we all focus on a more efficient use of health care resources.

Second, cost containment must be system-wide. We have just witnessed the latest round of Medicare cuts -- \$56 billion in the 1993 budget reconciliation act. Those cuts will do little to either slow the overall rate of health care cost growth in the economy or provide a long-term solution to the budget deficit. Just like the proverbial squeezing of one end of a balloon, cuts in Medicare-only payments to providers inevitably pop up in higher costs to employers and individuals. And even more troublesome for Medicare beneficiaries, Medicare-only cuts increase the chance that physicians and other providers will not treat them.

In order to contain health care costs in the economy, the President's plan establishes separate mechanisms for limiting public and private health care costs. Limits on public programs such as Medicare and Medicaid would come in the form of aggregate spending caps, enforceable through the congressional budget process. The new National Health Board and regional alliances would enforce premium limits in the private sector, which would be backed up with a penalty tax on health plans and providers if a limit is breached. AARP believes that these mechanisms -- if made to work in concert as part of a system-wide approach -- hold significant promise for containing costs. It will be important for Congress to establish the level and phase-in schedule for health spending limits based on the health care needs of Americans, and not based on arbitrary savings-driven targets. It will also be important to achieve an equitable balance between public and private savings.

The Medicare cap is estimated to achieve \$124 billion in savings between 1996 and the year 2000. Medicare cuts in the past ten years have already created large gaps between what Medicare and private insurance pay for the same service. Right now, Medicare pays an average of only 65 cents for every dollar that private insurance pays physicians. AARP strongly supports reducing and eventually eliminating this payment gap.

In the absence of system-wide cost containment and universal coverage, AARP would strongly oppose further Medicare cuts -- especially large-scale cuts such as \$124 billion. Even with comprehensive reform, we are doubtful that the Medicare program could sustain such enormous reductions without creating quality and access problems for beneficiaries. The Association will continue its assessment of these cuts -- which are alarming on their face -- as we examine the feasibility and effectiveness of proposed savings in the private sector.

Premium limits in the private sector would finally begin to address cost growth where heretofore there has been no constraint on spending. The Congressional Budget Office recently found that while Medicare spending grew at an annual per-capita rate of 3.1 percent between 1985 and 1991, total U.S. health spending grew at an annual per-capita rate of 4.8 percent. The reason for this difference is that Medicare is controlled through the federal budget process but private health care spending is not. The fact that Medicare pays for care of a generally higher cost population makes this disparity even more striking.

AARP generally supports the President's proposal to limit the growth in health plan premiums. If done right, premium limits could protect individuals and families from high costs in a way that is easily understood and broadly effective. And, it is premiums that are most visible today to the average family. We do not believe that premium limits necessarily will lead to lower-quality care or rationing of care as some provider and insurance interests suggest. The Association recognizes that Congress may need to revisit spending limits in both the private and public sectors after reform is in place, but it is critical to legislate system-wide and enforceable controls at the outset to guide insurer, provider, and consumer behavior.

The Association is concerned, however, that the lack of short-term cost controls in the President's proposal could lead to immediate "profiteering" by health providers and insurers at the expense of patients and consumers. Moreover, since the proposed Medicare cap would require substantial cuts in 1996 before the premium limits take effect, cost-shifting between Medicare and private payments could reach unprecedented levels.

AARP further believes that effective cost containment throughout the health care system will prove to be the linchpin for making reform work. If reform fails to control private-sector costs, then federal subsidies to individuals and businesses will be higher, gaps between Medicare and private payments will grow, and Congress will be faced with the choice of scaling back guaranteed benefits or generating additional revenues to pay for reform.

Financing

Just one year ago, many of the health care reform proposals circulating on Capitol Hill and within the Administration lacked at least one fundamental element -- financing. While no one pretended that paying for health care reform would be easy, only a few proposals contained explicit funding sources. AARP commends the President for establishing at the outset of the debate explicit financing for comprehensive reform. We look forward to an open discussion of the cost and financing estimates as congressional committees and the public demand proof that health care security can be financed as proposed by the Administration. This scrutiny is critical because if the proposed savings and revenues do not materialize, then important benefits will be reduced and/or the entire reform effort may be jeopardized. Experience has shown that cost estimates only grow as the legislative process advances.

The Association supports the President's call for "sin" taxes on tobacco as both a much-needed source of revenue and a disincentive to smoking. Of concern, however, is whether the estimate of revenue from a higher tax is realistic given that such a tax can be expected to reduce utilization. Congress should consider expanding this policy to include alcohol, which also contributes to health care costs.

We also support the President's effort to build upon existing financing mechanisms, particularly the requirement that employers pay at least 80 percent of health plan premiums. Nevertheless, AARP believes that broader, more progressive, and more stable sources of revenue are needed to accomplish comprehensive health care reform. In our own plan, "Health Care America," we proposed an option of a 3 percent income tax or 5 percent VAT dedicated entirely to health care. Both tax options proved acceptable to our members when linked to universal coverage for a full benefit package, including comprehensive long-term care.

More serious concerns are raised by the Administration's heavy reliance on planned reductions in Medicare and Medicaid spending to free up the federal funds necessary to provide universal coverage, to protect low-wage businesses and low-income individuals, and to provide additional benefits such as a Medicare drug benefit and long-term care. The Administration's plan projects \$238 billion in savings over five years from the cap on Medicare and Medicaid. Less attention has been given to an additional \$259 billion that would be transferred from Medicare and Medicaid to alliances to pay for current beneficiaries who are shifted into the alliances.

There is good reason to be skeptical about whether savings of this magnitude can or should be obtained from Medicare and Medicaid. During the 1980s, Medicare spending was cut by over \$80 billion cumulatively. Another \$43 billion was cut in OBRA 1990 over five years, and OBRA 1993 reduced spending an additional \$56 billion over five years. One of the serious risks of cuts of this magnitude is that they will institutionalize the disparity in reimbursement between private insurance and the Medicare program, making it more difficult for Medicare beneficiaries to gain or retain access to physicians. These savings, even if they can be achieved quickly, are not a permanent financing source. Once the system is made more efficient, we will need to identify more lasting funding sources for the public cost of health care delivery.

While we understand that the Administration's Medicare savings proposals are only an "illustrative" list and are comprised mostly of deeper cuts in provider payments, one proposal stands out as a significant departure from the current program -- income-relating the Part B premium.

AARP has strongly opposed this proposal outside the context of health care reform, arguing that it would constitute nothing more than a cost-shift to beneficiaries without adequate control over system-wide spending. We have also maintained that if Part B premiums were income-related, then premiums throughout the health care system should be income-related as well. It does not seem fair that taxpayers would continue to subsidize the health care premiums of a Wall Street executive with a salary of more than \$1,000,000 a year while subsidies to Medicare beneficiaries with much lower incomes are substantially reduced. If Congress and the President believe that "income relating" premiums is a good idea for the elderly and disabled, then it is at least as good an idea for the rest of the country.

Universal Coverage and Comprehensive Benefits

AARP is very pleased that the President's plan recognizes the importance of universal, comprehensive coverage. Two weeks ago, the U.S. Census Bureau announced that 2 million more Americans were without health insurance throughout 1992 than throughout 1991. This erosion of coverage cannot continue. As the President stated in his address to Congress: All Americans must have "health security; health care that can never be taken away; health care that is always there."

AARP strongly supports the requirement in the President's plan that premiums be community-rated so that individuals under age 65 are neither rewarded nor penalized on the basis of characteristics such as age, gender, or health status. Community rating is the most equitable way to share responsibility and risk across the American population. It is the way insurance should operate, and largely once did in this country. Community rating has important labor market benefits as well, since it substantially reduces disincentives for employers to hire and retain older workers.

Health coverage must not only be available; it must be affordable as well. Individuals alone cannot afford to pay the high cost of premiums, rather it must be a shared responsibility among businesses, individuals, and the government. The President's plan asks all employers -- as well as employees -- to contribute to the cost of coverage. AARP strongly supports this approach. This mandate would help to level the currently uneven playing field where some businesses -- including many small businesses -- pay more than their fair share, while others pay nothing. More importantly, employer contributions are critical to achieving universal coverage without substantial increases in federal income taxes. By requiring individuals to pay something toward their care, the President's plan can reinforce the principle of personal responsibility -- a principle already put into practice in the Medicare program through its premiums, copayments, and deductibles.

Legitimate concerns have been raised about the loss of jobs in the small business sector as a result of the employer mandate. In an economy as complex as ours, the net effect on jobs is difficult at best to estimate. However, estimates of the net effect on employment of AARP's "Health Care America" proposal, which includes universal coverage and an employer mandate, indicate that employment is reduced at most by only 0.3 percent in the first two years after implementation. By the third year, job growth resumes, and by the fifth year,

employment is higher than it would otherwise have been without reform. In other words, health care reform, even with an employer mandate, can be an investment in the nation's long-term economic growth.

Many working and non-working families will also need assistance in paying their share of premiums, deductibles, and coinsurance. While the plan notes that subsidies would be available to the under-65 population with incomes up to 150% of poverty, far more information is needed on the amount of the subsidies at each income level. We are also concerned that low-income Medicare beneficiaries might lose important protections. Currently, over 3.5 million Medicare beneficiaries are dually eligible for Medicaid benefits. An additional one million low-income Medicare beneficiaries are eligible to receive full or partial subsidies for Medicare-related out-of-pocket health costs through the QMB program. It is unclear whether such protections continue under the President's plan. It will be important to assure that these subsidies are maintained and strengthened in a reformed health care system, so that there can be a consistent policy for low-income persons of all ages.

What is and is not included in the benefits package is one of the most fundamental questions for consumers. The package proposed by the President takes a major step in covering a number of benefits that are typically omitted from or severely restricted in most private plans, such as immunizations, regular check-ups, mammograms, and other preventive services. We are also pleased that mental health and substance abuse services will be covered. We are concerned, however, that the limits on, and required cost-sharing for, both inpatient and outpatient care will prevent some individuals with mental illnesses from receiving needed services. The Administration's promise to place mental health care on a par with physical health care simply must be fulfilled by the year 2001, if not sooner.

AARP strongly supports a guaranteed comprehensive benefit package for all Americans. In that light, we are deeply disappointed that the President's plan would not provide the same coverage (i.e., the same benefit package, the same cost-sharing limits, the same limit on out-of-pocket spending, and full elimination of balance billing) for Medicare beneficiaries as it would for younger populations. We hope that these gaps can be filled as the proposal works its way through Congress. The need for health care, as well as the need for assistance to pay for that care, does not decline when one celebrates his or her 65th birthday.

Long-Term Care

AARP is particularly pleased that the President's proposal includes some coverage for home and community-based care for persons of all ages and incomes. The new program represents a serious though modest start towards addressing the unmet needs of millions of American families. The inclusion of long-term care is vital to our members and critical to AARP's support for any health care reform proposal.

Clearly, Americans of all ages strongly support such inclusion. A survey conducted for AARP this past April found that 90 percent of the respondents felt that including long-term care in a health reform proposal was important. Support for health care reform increased from 46 percent to 82 percent when long-term care was included. More recently, in a poll conducted for AARP less than two weeks ago, 86 percent of adults of all ages stated that they would be less in favor of the President's health care proposal if long-term care coverage were not included. And, in a study conducted last year for AARP by DYG, Inc., the amount that individuals were willing to pay for coverage increased substantially when both home care and nursing home care were included.

Long-term care is an issue that touches all of our lives at some point through family and friends. In our view, it makes no sense to provide protection against an acute illness but leave people vulnerable if they suffer from a chronic problem, especially since the need for these services is so interrelated. Persons with disabilities -- of any age -- are much higher than average users of medical services and require both kinds of care to meet their complex service needs.

Unfortunately, while approximately 37 million people lack basic medical insurance, virtually all Americans lack protection against long-term care expenses. Moreover, to a family sitting

around the kitchen table, there is no difference between spending \$20,000 on hospital care and spending \$20,000 on home care. It is still \$20,000 they probably do not have. To achieve true security, savings and quality in our health care system, coverage must not be limited only to the provision of services by a hospital or doctor; long-term care must also be included.

Since AARP is committed to advocacy for a health care program that will serve persons of all ages with disabilities, we are pleased that approximately one-third of the 3 million Americans who would receive help under this new program are under age 65. In addition, the proposal could finally provide much needed support and respite to caregivers--primarily mothers, wives and daughters--who are shouldering enormous burdens taking care of their loved ones. Many caregivers are jeopardizing their own health and, in some cases, are forced to leave the labor market, thereby suffering not only short-term loss of income, but also long-term reduction in Social Security and private pension benefits. Concern about the cost of long-term care -- financial as well as emotional -- is in fact greatest among those in the 50-64 year old group.

The Association is supportive of giving families choices and options they currently do not have, as the proposal would do. Our current system suffers from an institutional bias, which tears families apart and forces too many people to deteriorate slowly or go into nursing homes prematurely because they cannot receive care where they want it most--in their own homes or in supportive environments such as assisted living facilities.

Although AARP is pleased with the proposed expansion of home and community-based services, several questions and concerns remain. For example, the reliability of the funding for the program is a concern. Would funding be subject to annual appropriation or sequestration? Because a capped federal contribution is contemplated, we wonder what would happen if a state runs out of money before the end of its fiscal year. Could services simply be cut off? Will states be at risk and, therefore, less willing to participate in the program? The experience to date with an optional, capped program such as the Section 4711 Frail Elderly program does not inspire confidence.

Questions also remain regarding the basic structure of the new program. Although AARP generally supports state flexibility and experimentation, we are concerned that the tremendous variation and fragmentation that exists, especially under Medicaid, might persist. State flexibility needs to be balanced by clear federal standards to require the provision of basic services, to promote efficiency, and to assure that consumers are fully protected. In addition, it appears that states have the option not to participate in the program at all. Such an approach could pose serious problems if poorer states, for example, elected not to establish this program for its most vulnerable citizens.

In addition, although AARP supports the modest Medicaid improvements and private insurance standards proposed for nursing home care, millions would remain vulnerable to impoverishment due to lack of protection against these enormous costs. The single greatest fear which families confront in long-term care is the devastating costs of a nursing home stay which now average \$30,000 a year and reach \$60,000 a year in some parts of the country.

AARP looks forward to working with members of this Committee and with other members of the Congress to help ensure that long-term care remains an integral part of the health care reform package and that all Americans who suffer from serious chronic and disabling conditions receive the help they need.

Prescription Drugs

We are pleased that the President's health care reform proposal includes a comprehensive outpatient prescription drug benefit for all Americans, including Medicare beneficiaries. AARP is extremely concerned about the lack of access to prescription drugs (an estimated 72 million people do not have coverage), particularly among older Americans. The combined effects of high prices, heavy utilization, and the absence of affordable insurance coverage for prescription drugs have significantly limited access to needed drug therapies for older Americans. A recent national survey sponsored by AARP showed that:

- o older Americans use significantly more prescription drugs than other age groups to maintain their health;
- o prescription drug insurance coverage declines rapidly as age increases; and
- o out-of-pocket costs for prescription drugs are significantly higher for older Americans than for their younger counterparts.

As a result, many older Americans cannot afford high prescription drug prices and are too frequently denied access to essential, often life-saving, medications -- compromising their health status and making them more likely to receive unnecessary and more expensive acute care. About 10 percent of those surveyed said they have had to cut back on necessary items, such as food and heating fuel, to afford their medications.

The incorporation of a prescription drug benefit in health care reform will ensure access to important, often life-sustaining, drug therapies to all Americans, especially those who are most vulnerable to losing access today. Lack of a prescription drug benefit today contributes substantially to unnecessary hospital admissions and other conditions that can be prevented or controlled through pharmaceuticals. With more breakthroughs in drug development, medical care in the future will rely increasingly upon drugs and biotechnological products.

We are also pleased that the President's proposal includes strong cost containment mechanisms as an essential part of the Medicare drug benefit. We are concerned, however, that pharmaceutical manufacturers are already engaged in a major lobbying effort to eliminate any meaningful cost containment provisions from the proposed plan. In fact, we understand that the industry's leading association is attempting to scare Medicare beneficiaries into falsely believing that the President's cost containment efforts will result in the absence of Medicare coverage for important breakthrough drug therapies. We do not believe this is true.

In this regard, we strongly encourage the President and the Congress to remain firm in their commitment to contain prescription drug costs under the Medicare drug benefit. If effective cost containment is eliminated from the proposal, the Medicare drug benefit will quickly become unaffordable to both taxpayers and beneficiaries. This was clearly the case during the development of the Medicare Catastrophic Coverage Act (MCCA). Due to the lack of effective cost containment, the projected cost of the MCCA drug benefit (and the resulting estimates of premiums to be paid by beneficiaries) skyrocketed even before the bill made its way through Congress. Recent comments by Administration spokespersons about re-estimated drug costs and beneficiary premiums are therefore disquieting.

The pharmaceutical industry argues that every dollar sought by policymakers to contain drug prices will come directly out of research and development of important breakthrough medications. We believe this is simply false. Much more than legitimate research and development activities go into the manufacturer's price of a drug. Thus, drug manufacturers have many choices as to where they can be more efficient and cut costs.

In fact, according to a recent study by the Senate Special Committee on Aging, only 16 percent of the manufacturer's price of a drug goes toward research and development compared to the 36 percent that goes toward profits, marketing, and advertising. In addition, drug manufacturers' revenue will increase substantially under the President's plan as millions of Americans who currently lack coverage for prescription drugs will gain that coverage. Much of this revenue could be used for legitimate research and development endeavors.

Vulnerable 50-64 Year Olds

About half of AARP's 33 million members are under the age of 65. In listening to these members, we have discovered some disturbing trends. A 1992 study of public attitudes toward health care reform conducted by DYG, Inc. for AARP revealed that the 50-64 year-old population is much more critical of the health system than are other age groups. Not yet eligible for Medicare, this age group is the most concerned about the cost of health care and the security of their coverage. Only about half of 55-64 year olds are in the workforce, and

a disproportionate share of those who are employed earn low wages, work in smaller firms and industries least likely to offer coverage, or are self-employed. Gaps in coverage for this age group may also result from retirement or Medicare enrollment of an older spouse, divorce from or death of a working spouse, early retirement for medical reasons, or insurance industry underwriting practices that are increasingly squeezing less healthy individuals out of the group market.

AARP is pleased that the President's plan would provide health security for a segment of this vulnerable population -- so-called "early retirees." Such a system for retiree coverage would also help to restore the competitiveness of industries that have previously borne a disproportionate share of retiree health costs. According to the draft proposal, retired workers age 55 to 64 who meet the 40-quarter work requirement would receive a government subsidy for 80 percent of the premium for the nationally guaranteed benefit package. Former employers who now pay retiree health benefits would continue to contribute toward retiree coverage by paying the retiree's 20-percent share of the premium.

While this feature represents a significant improvement, the plan does not offer comparable protections for non-working, vulnerable 50-64 year olds who do not meet the Social Security requirement of 40 quarters of work. It is our understanding that retirees age 55 to 64 who do not meet this requirement would potentially be liable for the entire cost of their health premium in the alliance. This is of particular concern for women in this age group, who may not have the necessary work history but are now widowed or divorced.

A related concern is the plan's restriction of Medicaid coverage for supplemental services to recipients of cash assistance only (i.e., SSI and AFDC recipients). One out of every three current Medicaid recipients age 50 to 64 is eligible on a basis other than cash assistance. Over 20 percent of these near-elderly Medicaid recipients do not work and have incomes over 150 percent of poverty, leaving them without either employer contributions or federal subsidies to help ensure their access to health coverage under the alliances.

Some have suggested that a more straightforward, efficient, and fair way to assuring coverage for the 55-64 year old group is to lower the age of Medicare eligibility to 55. AARP believes that Congress and the President should consider this approach as a possible alternative to the more limited "early retiree" proposal.

Governance, Quality, and the Consumer

The President's plan proposes a new system for governing and organizing health care financing and delivery. For most consumers it will mean getting coverage, receiving information about health plans, evaluating quality, and lodging grievances through a new entity called a regional alliance, rather than going through an employer or an insurance company. The plan also proposes to establish a National Health Board at the federal level that would be responsible for setting national standards, enforcing the national health budget, and overseeing state administration of the new health system. Finally, the proposal gives states important new roles and flexibility in managing a reformed health care system.

We strongly agree with the President that our system for providing coverage and delivering care must be more responsive to consumers. Consumers need to have a say not only in their selection of health plans, but also in governance and assuring quality throughout the health care system.

According to a draft of the President's plan, states will play critical roles in health care reform. They will be responsible for establishing health alliances and qualifying and regulating accountable health plans. States will be given a great deal of flexibility to manage health care financing and delivery within their borders. While we recognize the innovations in health care financing and delivery developed in some states, we have serious questions about whether overly broad state flexibility will benefit consumers.

Under the President's proposal, for example, states could establish regional alliances as either nonprofit corporations or a state agency. If the alliance is a nonprofit corporation there must be a board of directors comprised of equal representation by consumers and

employers. If the regional health alliance is a state agency, however, there is no requirement for a board of directors. This poses serious questions about adequate consumer participation. We would suggest that the governance structure of any type of regional health alliance be controlled by consumers since they are both the recipients of care and the ultimate source of financing. While a few states have been pioneers in their effort to reform health care, most of AARP's experience with states -- who are faced with far more limited fiscal bases -- has been less than encouraging. Whether from the vantage point of nursing home quality standards or the manipulation of funds under disproportionate share hospital payments, the record of states does not recommend greater responsibility. Much more needs to be done in this area as legislation advances to assure good stewardship.

The Association welcomes many of the President's initiatives to improve the quality of care. Because accurate and useful consumer information will be critical to public accountability and choice, we are particularly pleased to see that an extensive consumer information program has been proposed. Among the elements of the new quality program that we applaud are: (1) the use of consumer surveys to measure access to and satisfaction with care, as well as its outcomes; (2) the development of uniform encounter and claims forms, key to a nationally standardized database, and (3) the development of a core set of quality and performance measures.

We must recognize, however, that it will take a long time to develop and implement the data systems which are envisioned, and that many critical performance and quality measures -- particularly those which measure the quality of care for persons with chronic physical and mental illnesses -- are not yet available. We believe that there must be sufficient resources to develop the necessary information and data infrastructures, and that these funding sources should be specified in the proposal.

While consumer information is a critical component in the overall quality assurance strategy, by itself it will not adequately address consumer concerns about the potential for poor quality care. As proposed, the plan does not clearly identify those entities that are to be responsible for protecting consumers from incompetent providers. Especially in light of the time it will take to develop an effective consumer information system, the apparent lack of external quality review, independent from payer (alliance) and provider (plan) responsibilities, seems to be an important "missing piece" in the proposed quality system.

In addressing these matters, the roles of state medical licensure boards and insurance regulators need to be carefully articulated. The proposal to eliminate the Medicare Peer Review Organization (PRO) program without a clear successor entity also raises a number of concerns. On the basis of what criteria would the decision that Medicare beneficiaries are adequately protected in the new system be made, and what entity or entities would pick up current PRO functions?

Another important consumer protection is access to independent and timely appeal mechanisms in the event of quality problems or denials of care. While the proposal does note that plans must provide "due process" for patients to appeal denials or reductions in coverage, these protections are not specified, and it appears that it would be left up to the plans to decide how much process is due. AARP believes that there should be nationally uniform due process protections for all consumers.

The Future of Medicare

AARP concurs with the decision to retain Medicare as a separate program. Indeed, in the President's plan, Medicare can be thought of as its own national health alliance. While we believe that ultimately the entire health care system should be seamless, we also believe that for the time being, it is preferable to permit Medicare beneficiaries to remain in a system that is tested and popular. Medicare beneficiaries simply do not have adequate experience with the alternative delivery systems that the President's proposal envisions would predominate in the reformed system. The current Medicare coordinated care strategies have not attracted sufficient numbers of beneficiaries or participating health plans to adequately test the viability of alternative delivery systems for older populations. HCFA reports that as of September 1, there were 1.7 million Medicare beneficiaries enrolled in risk HMOs--or

only about 5 percent of the 34 million Medicare beneficiaries. Furthermore, there are sections of the country where beneficiaries do not even have the opportunity to select a Medicare HMO. Mathematica Policy Research reported that in January 1992, participating plans served 40 different metropolitan areas across 28 states, which left half of the Medicare population without the opportunity to enroll in an HMO.

The limited experience that beneficiaries have had with alternative systems and their hesitation to deviate from the traditional Medicare program suggest that decisions concerning the integration of Medicare into the new environment should be made with great care. Currently, there is a system in place that is generally responsive to the special vulnerability of the Medicare population. Inevitably, as we begin to reform the nation's health care system there will be a period of volatility and instability in the system as new infrastructure is built and systems change. For those who are most physically dependent on the system, we believe that it is prudent to preserve a program with a good track record, at least until the new system has proven successful.

Treatment of Working Medicare Beneficiaries. It is our understanding that Medicare beneficiaries who are working will receive coverage through the regional alliances. We have a number of concerns about important details behind this proposal. For what benefit package would they be eligible? How will premiums for this beneficiary group be set? How much will employers, the Medicare trust fund, and beneficiaries each contribute?

Treatment of Individuals Turning 65 While in An Alliance. It is also our understanding that those turning 65 while in an alliance may elect to either remain in the alliance or join the traditional Medicare program. We are concerned that individuals who decide to join the Medicare program would be subject to higher cost sharing, no cap on out-of-pocket costs, balance billing, and less generous low-income protections -- in short, worse coverage -- than that available through regional alliances.

Other serious questions arise:

- o How much in premiums will these individuals be charged? The president's proposal clearly indicates that health plans will negotiate separate rates for those over the age of 65 who elect to receive coverage through an alliance and alliance members under age 65. It further indicates that Medicare will make a fixed contribution to the alliances "equal to the costs that Medicare would be projected to bear," but it is unclear how this calculation would be made.
- o Will beneficiaries who decide at age 65 to remain in the regional alliance have an opportunity to join the traditional Medicare program during each annual open enrollment period?
- o Will beneficiaries who choose traditional Medicare be able to purchase needed medigap coverage that is not medically underwritten?

While many individuals over 65 are likely to elect to receive health care through regional alliances, there will be a group of beneficiaries who continue to receive coverage under traditional Medicare. To adequately cover the costs of this group, it will be necessary to build-in an adjustment to the cap on federal spending for Medicare to take into account the higher expenditures that may be generated as this population ages.

State Integration. A further issue concerning integration of Medicare beneficiaries into broader systems is the proposed authority to allow states to integrate Medicare beneficiaries into health alliances. We are not convinced that states would be able to develop and maintain consistent, high standards with respect to oversight and enforcement that would be necessary to support a takeover of the Medicare program. Moreover, unless the Medicare funds were earmarked for use by beneficiaries, we would have concerns that states might divert such funds for other purposes.

If Congress decides to grant a limited number of states the authority to integrate Medicare into broader systems, the Association urges that such authority be conditioned on clear requirements and procedures that include ongoing federal oversight. Interested states must demonstrate and the federal government must ensure that Medicare beneficiaries will receive the same benefits as the under-65 population as well as appropriate access and high quality of care. Before entering into this type of arrangement with the states, the federal government must be able to justify with confidence and certainty how state integration will *improve* the current system. We do not believe that there is sufficient evidence at this point to support state control over the Medicare program.

Conclusion

In conclusion, Mr. Chairman, AARP commends the President, as well as the many members of Congress on both sides of the aisle who have brought the issue of health care reform to this stage. The President's plan incorporates many of the features that AARP has supported in its own proposal. At the same time, both the scope of the President's plan and the need for greater clarity on certain key provisions, not least of them financing and the ability to deliver the coverage promised, require careful consideration. We hope and trust that the next several weeks of hearings in the Congress as well as the Administration's continuing refinement of its proposal will contribute to a greater public understanding of all the plans before Congress and ultimately move the debate toward bipartisan legislation in the second session of the 103rd Congress.

If there's one thing we should all agree on, it's that the status quo is not an acceptable option.

Chairman STARK. Ms. Porter.

STATEMENT OF DIANNA M. PORTER, DIRECTOR OF PUBLIC POLICY, OLDER WOMEN'S LEAGUE

Ms. PORTER. Thank you, Mr. Chairman.

I would like to commend you and your committee for being willing to hear from various segments of the American population, including consumers.

The Older Women's League welcomes President Clinton's health care reform proposal, which offers substantial benefits to midlife and older women. We view the plan as a significant step forward—but not a complete answer to the health care crisis.

OWL continues to support the establishment of a federally funded and administered single-payer system on the national level as the best way to contain costs without sacrificing quality of care.

America's health care system must provide universal coverage that is affordable, equitable, and guarantees every individual, in their own right, comprehensive health coverage throughout life. A single-tiered health system with a single eligibility criterion and uniform administration and implementation best meets those goals.

We have examined the President's plan according to our organization's own health care principles, and my written testimony includes that in detail. But I would like to highlight some of the key points. First of all, under "Benefits," the Older Women's League is pleased with the community—

Chairman STARK. Ms. Porter, may I interrupt for just 1 minute. And for all the witnesses today, our microphones only work if you practically swallow them. So if you will bring it up real close, it will be easier for the reporter and our guests to hear your invaluable testimony.

Ms. PORTER. All right. I assume you don't want me to start over, though.

Chairman STARK. You may. But that is much better.

Ms. PORTER. OK. The Older Women's League is pleased with the community rating structure and the range of preventive, primary, specialized, reproductive, and long-term care services.

These services were promoted by the Campaign for Women's Health, a project of OWL. The campaign is a coalition of 80 women's organizations who are focusing on women's health needs.

We would like to see, however, under the benefits that there be covered, clinical preventive services for Pap smears and pelvic exams, also that there be clarification on mammograms, as we understand the National Cancer Institute has revised its recommendations.

We recommend that treatment schedules be established consistent with evolving research, and that a standard be established that allows health providers to order these and other screening tests based on the health needs of an individual woman. We also would recommend inclusion of osteoporosis screening as a covered clinical benefit.

We do applaud the inclusion of prescription drugs under Medicare, and the acute plan. Such a benefit is very important to older women. Pharmacy reports indicate that women over age 65 spend \$6.5 billion annually on prescription drugs. However, we are con-

cerned with the premium increases in addition to the deductibles. And 20 percent copayment may not alleviate the stress for many older women with limited incomes. Mr. Chairman, I am sure you know the median income for older women is only \$8,100.

We are particularly pleased that the President's plan does include some provisions for long-term care services. Over the course of the past year, those of us who have been advocating for long-term care have heard various messages. First of all, we heard that long-term care would not be included at all because it was too expensive. Then we began to hear that it would be included but with a phase-in period of 15 to 20 years. Then we began to hear that it would be a means-tested program. So we are pleased to see that there is some long-term care services within the President's plan and that it is a reasonable phase-in period, and at least with the new home- and community-based program it is not a means-tested program.

We would like to see, however, that the institutional care be included as part of the continuum of long-term care and it should not be just limited to just those who are Medicaid eligible.

As far as the new home- and community-based services, we see that there is no additional benefit or guaranteed benefit to the services beyond an assessment, a care plan and personal assistance services. We hope with the high range of Federal funding that States will develop an array of services, but we do believe that there needs to be a gatekeeping mechanism from the beginning to make sure that individuals receive the needed services and it is not a provider-driven system. We do applaud the single-payer option on the State level as a first step. In fact, our organization in years past had developed a model bill to be used for introduction into State legislatures.

However, at a minimum, the new health care initiative should encourage a State, not discourage, State single-payer level programs. We do need careful monitoring over time to allow comparisons among States selecting alternative strategies to make the plan's goals.

One thing I would like to emphasize is the administration's focus on the training of primary care physicians. We hope that includes geriatricians.

We would also like to make a special plea that it include the training of long-term care workers. They are going to be in the front lines of providing long-term care services. We need to upgrade their training and also see that they get benefits.

The Older Women's League commends the President and Hillary Clinton for their leadership in bringing health care reform to this point. We pledge to work with the administration and with the Members of Congress, to assure that America's health care system provides universal coverage, affordable, equitable and comprehensive.

Mr. Chairman and members of the committee, throughout this century, reformers have attempted to reach a goal of access to health care for every person in America. This is our opportunity to ensure that goal is finally reached.

Thank you.

[The prepared statement follows:]

**TESTIMONY OF DIANNA M. PORTER
DIRECTOR OF PUBLIC POLICY, OLDER WOMEN'S LEAGUE**

MR. STARK AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE:

Thank you for the opportunity to testify before your subcommittee today. I am Dianna Porter, public policy director of the Older Women's League, and on behalf of OWL, we commend you and the subcommittee for your willingness to hear from diverse segments of the American population, including consumers, on health care reform.

Founded in 1980, OWL is the only national grassroots organization to focus exclusively on issues of concern to midlife and older women. Through education, research, and advocacy, we work for public policy changes to reduce the inequities women face as they age.

The Older Women's League welcomes President Clinton's health care reform proposal which offers substantial benefits to midlife and older women. We view the plan as a significant step forward, but not a complete answer to the health care crisis.

OWL continues to support the establishment of a federally funded and administered single payer system on the national level as the best way to contain costs without sacrificing quality of care. America's health care system must provide universal coverage that is affordable, equitable, and guarantees every individual, in their own right, comprehensive health coverage throughout life. A single-tier health system with a single eligibility criterion, and uniform administration and implementation best meets those goals.

We have examined the President's plan, dated September 7, 1993. My comments are based on how the President's plan measures against our organization's health care principles.

PRINCIPLES

As outlined in the President's plan, many of the ethical foundations of health reform are consistent with those established by OWL. They include universal access, comprehensive benefits, quality and equality of care, fair distribution of costs, personal responsibility, inter-generational justice, a single-tier system, single eligibility criterion, no exclusions for pre-existing conditions, patient self-determination, comprehensive benefits, and a system of budgeting for cost-containment.

COVERAGE

While OWL is pleased that the President's plan would cover all Americans and legal residents, OWL's health care principles state that access is the right of all residents of the U.S. including those who do not meet the criteria set forth in the plan. We remain concerned that the cost shifting which now occurs when non-insured people delay getting health care or use emergency rooms will continue for people not covered by the plan. In addition, it is not clear how low-income people who do not meet the subsidy level determined by the plan, yet are unable to afford premiums or copayments for services, will obtain a health security card or services to which they would be entitled by virtue of having the card.

Although the Older Women's League prefers a health care system that is not tied to employment, we support the employer mandate which extends to independent contractors and part-time workers, the majority of whom are women who generally lack coverage under the current system. However, if a part-time worker is covered on a pro-rated basis by one employer and fails to work for a number of employers sufficient to equal an employer contribution of 80% of a premium, she would have to pay more than 20 percent of her premium. Currently a midlife woman who works part-time has an average weekly income of \$161.00. Without adequate subsidies and income thresholds for such subsidies, the cost sharing requirements will be onerous

for part-time workers.

Generally, OWL questions whether the subsidies for low-income individuals and small employers will be sufficient and that access to the subsidies will be uncomplicated. While OWL supports the plan's exclusion of cost sharing for certain preventive services, we believe that subsidies should be in place for persons with an income below 200% of poverty. We recognize that all individuals should be responsible for some part of their health care costs, but at the same time we do not want low-income people who may suffer from significant illnesses to be discouraged from obtaining needed services.

There must be clear guidelines established to ensure that people eligible for subsidies have easy access to those subsidies and that information on how to obtain the subsidies are available in different languages and in different settings including non-governmental community programs.

BENEFITS

The Older Women's League is pleased with the community rating structure and the full-range of preventive, primary, specialized, reproductive, and long-term care services. These services were promoted by the Campaign for Women's Health, a project of OWL. OWL would like to see family planning and pregnancy-related services defined to avoid ambiguity as the plan is debated. For instance, it would be unacceptable for all the plans in a particular alliance to exclude abortion counselling or abortion services. OWL is disappointed that dental, eye, and mental health care will be limited until the year 2000.

It appears that the covered clinical preventive services do not include Pap smears and pelvic exams for women over age 65. Yet the highest rates of ovarian and uterine cancers occur in women age 65 and over. Medicare currently only helps to pay for Pap smears to screen for cervical cancer once every three years. We believe that Pap smears and pelvic exams for women over 65 should be included.

Although there continues to be inadequate research on the underlying causes and prevention of breast cancer, it is imperative that the plan draw on the most recent and randomized studies. Where there is inadequate information we believe there should be a greater rather than lesser emphasis placed on the use of mammograms. Most experts agree that women should have a baseline mammogram at age 35 and another at age 40. The National Cancer Institute is revising its recommendations of a mammogram every 1 to 2 years for women 40 to 49 and annually for women over age 50. We recommend that treatment schedules be established consistent with evolving research and that a standard be established that allows for health providers to order these and other screening tests based on the health needs of an individual woman.

The Older Women's League recommends inclusion of osteoporosis screening as a covered clinical service. Osteoporosis is a major debilitating disease characterized by the chronic loss of bone mass and is a major cause of fractures of the spine, hip, wrists, and other parts of the skeleton. It affects an estimated 24 million Americans--about half of all women over age 45 and nine of ten women over age 75--and leads to approximately 50,000 deaths per year. Bone mass measurements assist physicians in identifying risk in post-menopausal women and others. Preventive and treatment measures can then be taken.

In reviewing the benefits section, we are concerned that some of the benefits which are currently available to Medicaid recipients, including supportive services such as transportation and dependent care, are not mandated in this plan. While we are very pleased that under the acute plan, Medicaid recipients participate in the plan like anyone else, their inability to access services because of inadequate transportation or

dependent care can pose insurmountable barriers. We would like to see a mandate rather than an option or incentive program offered to the states to remove these barriers.

We would also like to see greater clarity on the role of the primary provider and the role such a provider would play in a consumer obtaining access to specialized care. We believe geriatricians play a critical role in the delivery of services to the elderly and urge they be considered primary providers.

OWL applauds the inclusion of prescription drugs under Medicare and the acute plan. Such a benefit is very important to older women. Pharmacy reports indicate that women over age 65 spend \$6.5 billion annually on prescription drugs. However, OWL is concerned that the premium increase (estimated now at \$12 a month), in addition to the \$250 annual deductible and 20 percent co-payment, will not alleviate the stress on many older women with limited incomes (the median income for older women in 1991 was \$8,189 compared to \$14,357 for older men). For example, if an older woman needs on average \$500 of prescriptions a year, she will have to first pay \$394 in premiums and deductibles (plus \$50 of co-pay on the remaining \$250 in costs after the deductible).

LONG-TERM CARE SERVICES

Eligibility. Eligibility for home and community based services based on three activities of daily living (ADLs) or need for supervision of these activities is within parameters acceptable to OWL. However, we hope that eligibility at such a high level of disability will not be locked in place permanently and that there will be a reduction to two ADLs eligibility by the end of the phase-in period.

The Older Women's League is pleased that the long-term care program will not be a means tested one. It is likely that low-income persons will be the population primarily served by the program but the acceptance of the new program by the American public will depend on its availability to all.

Raising the spend-down level for Medicaid eligibility for nursing home care for single persons from \$2,000 to \$12,000 and an increase in the personal needs allowance to \$100 a month are improvements to Medicaid coverage for institutional care.

Cost-sharing. The sliding fee scale for those individuals with incomes above 150 percent of the federal poverty standard meets OWL's principles that any cost-sharing must be income-based. We are concerned, however, that setting cost sharing at 150 percent of the poverty level is too restrictive (the poverty level for one person over age 65 in 1992 is \$6,729, and \$7,299 for single persons under 65). OWL recommends that the level for cost sharing be raised to 200 percent of the poverty level and that states may not impose cost sharing on income below 200 percent of the poverty line.

Benefits. A full continuum of long-term care services, including those in institutional settings, must be available under a comprehensive long-term care plan.

Although OWL supports the development of alternatives to institutional care, OWL has the following concerns:

- that such alternatives do not implicitly assume that "informal" caregiving services offered primarily by women are available, and that there be recognition of the limits and needs of informal caregivers;
- that alternatives to institutional care be broadly defined to include a variety of options;

- that the care services now required are too restricted. Assessment and care planning diverts money to the professional without guaranteeing that the necessary attendant services will then be available. We would add that assessment and care planning should not be used to substitute for needed direct services such as respite, transportation, day care, homemaker, home health and other essential care;

- that the emphasis on alternatives do not detract from the need to improve institutional care for those who cannot live outside institutions. Therefore, the plan must provide for public benefits not based on Medicaid criteria. Above 200% of the poverty line there should be cost sharing based on a sliding scale with assured levels of protection for the community spouse;

- that the benefits for children and others should not require rehabilitation potential as an eligibility criteria.

Although the President's revised plan requires only a minimum benefit of a standardized assessment and an individualized care plan for those deemed eligible by the states, OWL hopes that the federal matching rate of between 75% and 95% will encourage states to develop comprehensive home and community based services. To ensure that this occurs, the LTC benefits should be stated and guaranteed just as the acute care benefits are.

In addition, OWL would like to see consumer safeguards included in the long-term care plan like those in the acute plan. Such protections could include the creation of an ombudsperson program.

It is also not clear how states will integrate the three LTC programs i.e. the new home and community based services; the Medicaid residual community LTC (those currently receiving Medicaid community LTC services who are low-income but who do not meet the eligibility criteria of the new program), and the Medicaid institutional. This is not required in state plans. We understand a revision to the President's plan would establish two advisory groups--a federal group advising the Secretary of Health and Human Services, and a state advisory group of consumers, providers, state officials and others. We hope that this addition will facilitate states' integration of the programs.

State Flexibility. OWL sees the following as positive outcomes of state flexibility: States will design the home and community based services based on the needs of the residents of that State. For example, the delivery of certain services will differ in largely rural states from those largely urban. State advocates for the elderly believe states can provide a better array of services (and services tailored to individual needs) than any that may be mandated by the federal government. The federal government (DHHS) would establish a national budget for the home and community based services program and a formula for allocating funds to the states.

However, there is no additional guaranteed benefit to community services beyond the assessment and care plan and availability of personal assistance services for those determined eligible by the states. It is hoped that with a high rate of federal match, the states will have attractive options to develop comprehensive home and community based services. OWL believes that a gate-keeping mechanism be an integral part of the long-term care system from the beginning to assure needed services are received and to avoid a provider-driven system.

Tax Incentives for Private Long-Term Care Insurance. The Older Women's League is concerned that the tax incentives will perpetuate insurance policies that are costly and beyond the financial resources of most older women. Accordingly, OWL opposes the government subsidizing these policies, although it does support the adoption of strict guidelines to protect consumers who are purchasing these policies.

Research.

As the need for services are often not readily demarcated into acute and chronic categories, OWL supports the establishment of a demonstration program for integrated models of acute and long-term care services. We support the ultimate integration of the acute care and long-term care programs.

INDIVIDUAL ELECTION AT AGE 65 TO REMAIN IN HEALTH ALLIANCES

The Clinton plan provides for individuals to remain in a health alliance upon reaching age 65 in lieu of moving to coverage under Medicare. However, the individual is subject to a higher premium rate than younger participants. OWL believes that such a premium rate for older individuals is inequitable and provides a disincentive, not incentive, for remaining in a health alliance plan.

EARLY RETIREE PROGRAM

Protection for early retirees will assure that persons between the ages of 55 to 65 have health care coverage. This provision in the plan is of great importance to midlife women who often find that when they are no longer in the workforce, for whatever reason, they are usually without health care coverage. A guarantee that the federal government will pay for 80 percent of their coverage is crucial to their protection.

LARGE EMPLOYER "OPT OUT"

OWL opposes an employer "opt out" of the plan. Such an approach encourages the continuance of self-insured plans in businesses with younger, healthier workforces. This discriminates against high risk individuals and perpetuates the current situation in which poor health status is a barrier to employment. Although the Clinton plan would require employers opting out to pay a subsidy, nevertheless, OWL believes that large employers opt outs would make coverage more costly for small employers and individuals as well as the government.

SINGLE PAYER OPTION

OWL applauds the single payer option on the state level as a first step. Our organization has already developed a model bill that can be used for introduction into state legislatures. However, the President's plan calls for states to apply for waivers in order to establish a single payer system and to find revenue from "sources other than those provided by this Act." These constitute a burden on states choosing the single payer option. At a minimum, the new health care initiative should include incentives to encourage single payer state level programs. Careful monitoring over time will then allow comparisons among states selecting alternative strategies to meet the plan's goals.

DECISION-MAKING REPRESENTATION AND ACCOUNTABILITY

OWL's health principles call for women of all ages, income levels, and racial and cultural backgrounds in decision-making positions. Under the President's plan, the National Health Board will consist of seven members appointed by the President. However, there are no provisions for types of representation. We recommend that the plan clearly provide for an increased number of consumer advocates representing diverse populations.

OWL supports the plan's mandate that the regional health alliance boards have an equal number of employer and consumer representatives, and that an ombudsman program is created to assist consumers who have problems with their health plans and the alliance.

RESEARCH

Overall, the provisions pertaining to research are a major step forward. However we believe all research which is conducted should include breakdowns on the basis of race, gender and age groups (in ten year increments) to take into consideration biological and other differences.

The Older Women's League is pleased that the Administration has included as a priority area for prevention research chronic and recurrent illnesses, including research on Alzheimer's disease, cancer, cardiovascular diseases, bone and joint diseases, and other chronic diseases and conditions. All of these conditions afflict older women in particular.

Mental health research in the President's plan will include women's mental health, mental disorders in the elderly and their caregivers, and violence. Our research on caregivers has found that caregiving takes a toll physically, economically, and emotionally on those providing the care. We are pleased that the mental health needs of caregivers are recognized. In addition, ending violence against women and the elderly is part of OWL's national agenda.

OWL also approves of research on health and wellness promotion which includes an emphasis on fitness for all ages, and fitness and aging.

Health Services Research will include effectiveness, quality and outcomes research, research on consumer choice and decision making and information resources, and evaluation of health care reform. These address one of OWL's health care principles calling for research that looks at the correlation of the evolving health care system and its social and economic impact.

TRAINING A NEW HEALTH WORKFORCE

While the administration's plan acknowledges the need to encourage more primary care physicians and training for nurse practitioners, nurse midwives, and physician assistants, OWL would also like to see chronic care workers, those who work as home health and nursing home aides, included. These workers will be on the front lines in providing long-term care services and need training and improved wages and working conditions. We recommend that demonstration projects be developed that look at the role of the chronic or long-term care worker—including the establishment of career ladders--and integration of these workers in the care plan of the person in need of services.

FINANCING

The Older Women's League believes that the financing of a health program should be based on progressive approaches including employer payroll taxes, income taxes, state and local resources, and modest co-payments. OWL is not opposed to the so-called "sin" taxes, but is concerned that the excessive cuts to Medicare may affect quality of care and create disincentives for health care providers to serve Medicare patients. In particular, we would want to see a limit placed on the amount of costs created by copayments for tests. In addition, we are troubled about the effect the Medicare cuts will have on disproportionate share hospitals--those serving low-income persons. Just as the plan contemplates creating incentives to support underserved areas of the country or particular populations, such incentives should exist to encourage ongoing services to Medicare recipients.

CONSUMER BILL OF RIGHTS

A consumer bill of rights should be provided throughout the entire system to guarantee consumer grievance and appeal procedures as well as consumer involvement on quality oversight and enforcement in the health alliances, Medicare, and long-term care programs. There should be annual performance reports on

Medicare providers as well as the acute care plans and providers.

MEDICARE INTEGRATION

OWL would support the integration of Medicare into a single payer plan. However, under the Clinton proposal, we are not prepared to comment on moving Medicare into the current plan as a variety of concerns need to be addressed. OWL proposes research on the implications of keeping Medicare separate from the health alliances.

SUMMARY

The Older Women's League commends President Clinton and Hillary Rodham Clinton for their leadership in bringing health care reform to this point.

We are particularly pleased with the inclusion of long-term care as an essential part of a universal health care plan. This is a vital concern for women who both provide the majority of family caregiving and are most likely to require such care as they age. Many women assume eldercare responsibilities at a time of crisis and may continue to provide the quality care they feel their loved one deserves for years--with no outside support. In addition, women are more likely than men to suffer from chronic illness, while being least able to pay for health care.

To achieve optimal benefits, states must be assured adequate funds to offer a full array of all long-term care services, including institutional as well as home and community-based care.

The inclusion of prescription drugs in the President's plan is also an important provision. Older women have an annual median income of only \$8,139 and must frequently forego purchasing prescription drugs that would alleviate their chronic conditions.

OWL pledges to work with the Administration and you, the members of Congress, to ensure that America's health care system provides universal coverage that is affordable, equitable, and comprehensive. Throughout this century, reformers have attempted to reach a goal of access to health care for every person in America. This is our opportunity to ensure that this goal is realized.

Chairman STARK. Ms. McSteen.

STATEMENT OF MARTHA MCSTEEN, PRESIDENT, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Ms. MCSTEEN. Mr. Chairman, members of the committee, I am pleased to represent the National Committee this morning.

Since we have not yet seen the legislative language of the plan, my comments are necessarily preliminary. The Clinton administration, with its comprehensive proposal, has moved the health care debate forward by an unprecedented leap, providing a window of opportunity for the Members of Congress such as you, Mr. Chairman, and other members of the subcommittee, who have worked for so many years to improve our health care system.

I would like to talk today about three issues: The prescription drug and long-term care provisions; financing; and, last, the National Committee's concerns about equity.

The National Committee applauds the President's proposals to expand Medicare to cover prescription drugs and to provide funding for community- and home-based care for the severely disabled.

Long-term care is an integral part of the health care continuum, and this Federal-State matching grant for home- and community-based care is a critical first step. If seniors must choose, National Committee members, 8 to 1, want a home- and community-based benefit.

Our greatest concern with the administration's plan, as we know it, is the ambitious reduction in Medicare spending of \$124 billion over 5 years. We question whether it is possible to reduce the program to such a degree without seriously hollowing out the program, leaving an empty shell.

At a minimum, reductions in Medicare spending must go hand-in-hand with reductions in private sector, health care spending. It is unclear whether reductions in private sector health care spending can or will take place as quickly as predicted.

Many of the proposed Medicare savings are increases in already high, out-of-pocket costs for Medicare beneficiaries. We believe these higher out-of-pocket costs could create an excessive burden on many seniors who may also pay a higher premium for prescription drug benefits.

The National Committee would like to see a mechanism to earmark savings from Medicare reductions for the Medicare prescription drug benefit and the long-term care benefit.

The administration's proposal to provide health security for early retirees between 55 and 64 raises important issues that Congress should consider. Without question, some in this age group of early retirees are vulnerable to losing health insurance and could greatly benefit from the proposal.

We encourage Congress to address the problem of this age group in a manner that does not adversely impact the Social Security and Medicare programs or create disparities in the treatment of retirees.

With regard to out-of-pocket costs, it appears that the health care reform plan treats Medicare beneficiaries inequitably. Non-Medicare beneficiaries would have a cap on total out-of-pocket costs

for deductibles and copayments and better mental health and preventive care benefits than Medicare beneficiaries.

Medicare beneficiaries will also pay more in premiums than working Americans.

The administration would mostly leave untouched the tax break given to employer health insurance contributions and even expand it to the self-employed. But the administration stops short of extending a similar tax break to other Americans.

Moreover, we are strongly opposed to increasing the part B premiums on upper-income beneficiaries, while leaving the tax deduction in place for employer-paid health insurance for upper-income employees.

In conclusion, we look forward to reviewing the administration's bill and continuing to work with the White House and the Congress as the discussions on health care reform continue.

We have a responsibility to let your constituents and our members know exactly how a new health care proposal affects them.

Members heard the President's speech at our events and indicated so by raising their hand. But when asked by a show of hands, they did not know whether the administration's plan would affect them personally.

Thank you very much. Thank you.

[The prepared statement follows:]

TESTIMONY OF MARTHA McSTEEN, PRESIDENT NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Mr. Chairman, members of the Committee, I am Martha McSteen, President of the National Committee to Preserve Social Security and Medicare. I am pleased to be here today to provide some initial reactions to the Administration's draft health care proposal as seen from the Medicare beneficiary perspective. Since we have not yet seen the legislative language of the plan, my comments are necessarily preliminary.

Universal Coverage

The Clinton Administration with its comprehensive proposal has moved the health care debate forward by an unprecedented leap—providing a window of opportunity for the Members of Congress, such as you, Mr. Chairman, who have worked for many years to improve our health care system. It is exciting that within the foreseeable future there could be universal coverage—not just access to health care—with a generous standard benefit package for those under 65. It is long overdue and seniors will be only too pleased to know that their children and grandchildren, too, will be protected against financial devastation when illness strikes.

I would like to talk about three issues:

- The prescription drug and long-term care provisions
- Financing, and lastly,
- National Committee concerns about equity

Prescription Drugs

The National Committee applauds the President's proposal for expanding Medicare to include prescription drugs. Given the generous benefit, some seniors may accept a possible premium of \$8-\$12 a month, but for others even that could be difficult. Most seniors with retiree health benefits provided by a former employer, however, may see this as just an extra cost because they already have some prescription drug coverage. Poor Medicare beneficiaries, we understand, will be protected from the increase in premium costs by Medicaid, Qualified Medicare Beneficiary program or the Specified Low-income Medicare Beneficiary program.

Long-Term Care

The National Committee likewise applauds the President for including long-term care in his proposal. Long-term care is an integral part of the health care continuum and this federal-state matching grant for home and community-based care is a critical first step. While seniors also need long-term care in nursing homes, \$34 billion toward home and community-based care is a good beginning. If they must choose, National Committee members, eight to one, want a home and community-based benefit over an institutional based benefit of equal funding size.

Thirty-four billion dollars comes to less than \$1,000 per month for the approximately three million severely disabled people estimated to be eligible. This does not include the state match of between 5 to 25 percent or the sliding scale co-payment. However, much of this amount could be absorbed by the cost of the important function by care managers to perform the assessments and develop care plans. An average of \$1,000 is not excessive considering that adult day care may cost \$35-40 a day and home care at least \$15-25 per hour depending on the geographic area. Nonetheless, this grant to states would clearly help support efforts already under way in many states. The shorter the implementation period the better.

The National Committee would oppose a premium on just Medicare beneficiaries. If a premium is necessary to help finance this benefit, the National Committee strongly recommends that all taxpayers be charged a small premium—not just a surcharge on Medicare premiums—since the benefit is available for severely disabled people of all ages.

National Committee also supports relaxing the Medicaid asset test for nursing-home bound individuals and increasing the monthly allowance to nursing home residents. These provisions provide more dignity to the lives of this population. We are pleased that Federal standards for private long-term care

insurance are part of the proposal—something the National Committee has long supported.

While the Administration proposal provides small improvements to Medicaid nursing home coverage, it says nothing about the need for increased financing needed to improve care in nursing homes. Both licensed nurse and nurse aide staffing is inadequate in nursing homes across the country. The Pepper Commission recognized that "access to quality care would require higher rates than many Medicaid programs now require."

Financing

Our greatest concern with the Administration's proposal, as we know it, are the ambitious reductions in Medicare of \$124 billion over five years in order to bring down the rate of increase to 4.1 percent by the year 2000. We question whether it is possible to reduce the program to such a degree without seriously hollowing out the program, leaving an empty shell. Overall, Medicare and Medicaid savings are expected to finance more than half of the new government spending on health care reform.

At a minimum, reductions in Medicare spending must go hand in hand with reductions in private sector health care spending. It is unclear, however, whether reductions in private sector health care spending will take place as quickly as the Administration envisions. Certainly, there is a lot of waste in the health care system. If we try to reduce costs too rapidly, however, we could disrupt the health care system. While the disruptions may only be short-term, it could cause public disenchantment with health care reform during the critical start-up phase.

Many of the proposed Medicare savings are not cuts in reimbursements to doctors and hospital, but increases in already high out-of-pocket costs for Medicare beneficiaries. According to one Administration estimate, increases in out-of-pocket costs could total more than \$45 billion over five years. These savings are expected to come from four areas, setting Part B premiums into law, 20 percent co-payment for laboratory tests, 10 percent co-payment for home health services 30 or more days past a hospital stay, and from requiring higher-income beneficiaries to pay more for their coverage. We believe these higher out-of-pocket costs could create an excessive burden on many seniors who may also pay a higher premium for prescription drug benefits.

Also, we are uncomfortable with the seemingly conditional connection between the new prescription drug and long-term care benefits and reductions in Medicare. What will happen to these benefits if the saving in Medicare are not realized? We are also concerned that these new benefits may be cut back if other parts of the plan are more costly than anticipated. The National Committee would like to see a mechanism to earmark savings from Medicare reductions to guarantee that they will be used for the Medicare prescription drug benefit and the long-term care benefit. We believe this could be done by making it a part of the budget enforcement provision.

The Administration's proposal to provide health security for early retirees between 55 and 64 raises important issues that Congress should consider. Without question, this age group of early retirees is vulnerable to losing health insurance and will greatly benefit from the universal coverage plan which guarantees access to health insurance. However, we are concerned that providing a government subsidy for 80 percent of premiums would create a significant incentive to leave the job force. Reductions in contributions to the Social Security and Medicare trust funds could have a detrimental affect on the future of these funds. We are giving retirees a double message. On the one hand, we are gradually postponing Social Security retirement age to 67 beginning in the next century, and, on the other hand, we are encouraging early retirement by subsidizing health benefits. We also are concerned that it creates a disparity between retirees under and over age 65.

Medicare savings of \$22 billion over five years will come from implementing a long overdue outpatient hospital prospective payment system. We are also counting on the Administration keeping in the plan an equally overdue reform of the beneficiary co-payment formula for outpatient hospital services so that beneficiaries pay no more than 20 percent of what Medicare allows. Currently, beneficiaries pay 20 percent of the hospital-computed charges.

Equity Between Medicare and Non-Medicare Beneficiaries

There are four specific equity concerns:

- 1) out-of-pocket costs
- 2) premiums
- 3) tax breaks
- 4) sharing the costs for health care reform

The National Committee agrees with the President that Medicare should be left out of the larger system for now until the new system has been established and fully implemented. However, the two programs should be identical. Otherwise, many Medicare beneficiaries may join the health alliances not because they are impressed with the health care but because they can get more coverage.

Out-of-pocket costs. In spite of the welcome new prescription drug and home and community based care benefits, it appears that the health care reform plan treats Medicare beneficiaries inequitably. Non-Medicare beneficiaries would have a cap on total out-of-pocket costs for deductibles and co-payments, no balance billing and somewhat better mental health and preventive care benefits than Medicare beneficiaries. The new Medicare benefits are also partially offset by proposed increases in co-payments. It would be ironic if the 500,000 seniors who do not have Medicare and early retirees under health care reform actually receive better health insurance than Medicare beneficiaries.

Premiums. Medicare beneficiaries will also pay more in premiums than working Americans. Under current law, Medicare premiums are \$36.60 per month this year and \$41.10 per month next year. In addition, Medicare beneficiaries could pay \$8 or more per month for prescription drug coverage. Prescription drug coverage will be added to Part B which is partially financed by a premium which generally covers 25 percent of program cost. In contrast, under the draft plan, total premiums for working individuals under health care reform are estimated to be only \$30 per month at the most, \$15 to \$20 less per month than Medicare beneficiaries.

We assume that Medicare beneficiaries will still have to pay the same higher premium even if they join an alliance health care plan. This will be even more unfair if upper income beneficiaries are also required to pay higher Part B premiums because the Administration apparently would not impose higher premiums on upper income non-Medicare beneficiaries.

Tax breaks. Despite the recommendation of many managed competition advocates, the Administration would mostly leave untouched the tax break given to employer health insurance contributions and even expand it to the self-employed. But the Administration stops short of extending a similar tax break to other Americans, including Medicare beneficiaries, who do not have generous employer paid health benefits. If an employer pays the whole health care premium, the employer contribution would continue to be tax free for employees while many workers and Medicare beneficiaries will pay premiums in after-tax dollars. Moreover, we are strongly opposed to increasing the part B premiums on upper income Medicare beneficiaries while leaving the tax deductions in place for employer-paid health insurance for upper-income wage earners.

Sharing the costs for health care reform. Most working Americans will pay little or nothing for health care reform unless they smoke. In contrast, Medicare beneficiaries will have an increase in the Part B premium and new co-payments for home health care and labs and higher income beneficiaries will pay even more. The proposed Medicare cuts to providers also could "cost" Medicare beneficiaries in terms of access and quality.

Remaining Questions

Many questions remain unanswered. For example, can Medicare beneficiaries freely go in and out of the health alliance system during the annual enrollment period, or are they restricted to a one-time decision at age 65? The National Committee recommends free access to the health alliance system at any age. Allowing seniors to try out the new system may help break down resistance to change if the two systems eventually become one.

Will Medicare beneficiaries pay more if they receive health insurance through a health alliance plan versus going with Medicare? It is essential that Medicare beneficiaries, whether brought in under a state-wide plan or joins a health alliance voluntarily, is guaranteed the same level of benefits for the same cost as under Medicare.

What will be the impact of the new system on quality of care? The National Committee applauds the call for consumer information, internal quality improvement programs and the collection and feedback of performance and outcomes data to health plans to assist in this process. However, are we to understand that all quality assurance will be internal and educational, and that there will be no reporting requirement about poor performance and no sanctioning of such providers and practitioners?

What process will be put in place to establish premium limits? The National Committee supports some form of global budgeting and reasonable premium rate caps as a way to contain health care costs. But the process to establish such limits must include a negotiation process by representatives from affected parties so as not to affect quality of care.

What will the effect be on medigap policies besides changes to reflect the new prescription drug benefit? If Medicare beneficiaries are allowed to go in and out of the Medicare program, medigap policies should be available without waiting period for pre-existing conditions. Will the premium controls also apply to medigap? Will Medicare beneficiaries who choose alliance coverage be required to pay the Medicare Part B premium which is currently optional? What about upper-income Medicare beneficiaries, will they pay higher Part B premiums even if they choose alliance coverage?

These are just a few of the many questions remaining. We hope that some of these will be answered in the legislative language soon to be released.

Conclusion

The National Committee supports health care reform including a prescription drug benefit for seniors and long-term care for all ages. We applaud the President's initiative and look forward to continuing to work with the White House and the Congress as the discussions on health care reform continue.

Chairman STARK. Thank you.

I just wanted to start out by calling attention, if I could ask the members and Ms. Brown, to refer to page 2 of the AARP's written statement; and I just wanted to review a few points here, because as we will encourage other groups to do and as the Chair has often been admonished, if you don't like this plan, what do you like?

And the AARP has forthrightly suggested what they do mean. They want a Federal, as they say, guarantee. And they want—I presume by “systemwide cost containment,” you mean “nationwide cost containment.” And they want comprehensive benefits—I don't think there is any person on this subcommittee that has a limit to the comprehensiveness of the benefits. We have some feeling we may not be able to pay for the benefits that would fit into our definition of that.

You want delivery system reforms that increase access. Again, I have a hunch that you would find unanimous support. And you want broad-based, fair, and affordable financing. We might have some trouble defining just what that is. But in general we would agree with you.

You then get on, in the next paragraph, at least to the nubbins of the chairman's delight, and that is in your “Health Care America.” Your centerpiece is a strengthened—if I am quoting properly—and expanded Medicare program through which everyone would be eligible for a comprehensive, nationally mandated package of medical and long-term care. And that employers would be required to contribute to the cost of their workers' benefits either through the expanded Medicare program or through private coverage.

I gather by that, that you would be comfortable with making Medicare a broader option for nonsenior citizens in this country. Is that correct?

Ms. BROWN. Yes. In our Health Care America, we had the same benefits available to everyone. It was a more expanded program than the President's program. But it was for everyone, yes, sir.

Chairman STARK. I am afraid probably more expensive than both you or I can figure out how to pay for. But I applaud you for setting us a high goal. And I am comfortable with that.

Ms. BROWN. We did, in fact, propose some funding for it, sir, because we felt that, to be honest, we had to do that.

Chairman STARK. In the limited time on the first go round, I would like to ask all of you just if you could answer as briefly as possible; and we will get plenty of time to let you expand on the answers.

But the administration's plan proposes to cut about \$125 billion from Medicare. That number may change when we see the numbers, but let us assume a large amount will come from Medicare. And the savings generated would be used to support a Medicare prescription drug benefit, which, as I read the original plan, would indeed be an entitlement.

But the long-term care is a block grant to States and not an entitlement. And I wonder, as representatives of seniors groups, whether you would support using savings from the Medicare program to support a block grant, rather than an entitlement, and whether you think that people you represent really understand that the

plan at this point does not include a new Medicare long-term benefit but a more general prospective benefit to the country.

And if the plan includes a new major expenditure for long-term care, would you not prefer that the initial benefit be to protect individuals against financially devastating, long-term care in nursing homes rather than supplementing short-term, occasional visits by home health care providers?

Ms. McSTEEN, do you want to start?

Ms. McSTEEN. Yes.

Chairman STARK. Is that your answer?

Then I will—

Ms. McSTEEN. Not at all. Not at all. You touched on a number of things that are very key to seniors. And the National Committee members' average age is 68, and so they are very interested in long-term care and insist that that be a part of the package.

Although in our polls, they do show that, 8 to 1, they would rather have the short-term care rather than the long-term care, because most people like to be at home if at all possible.

Chairman STARK. So they would prefer home health care rather than long-term custodial care.

Ms. McSTEEN. Yes. But I recognize that there are more people who would benefit by home care than those lower percentages that go to nursing homes. I do recognize that.

Chairman STARK. I want to ask you, Ms. Brown, that I have a hunch that—because I am waiting for Ms. Brown to answer. So I'll ask, Ms. Brown, if you will excuse me for just a minute. I have a hunch that Ms. McSTEEN's constituency, on average, is somewhat lower income than yours. But now having prefaced that, I would ask you how you would answer that question.

Ms. BROWN. I don't know the answer to that. But the average member of AARP is a 65-year-old woman who lives on Social Security and has about \$20,000 in the bank. So we maybe have the same constituency.

The older American person, the thing that they are interested in, and that their children are interested in, is enabling them to stay in their home as long as they can.

And the second great fear is that if they go into a nursing home, they don't want to have to go broke.

Chairman STARK. So you put that at the second level, rather than the first, as you interpret what you are hearing now.

Ms. BROWN. Yes. Obviously, we would like it all; but if we can't have it all—

Chairman STARK. Ms. Porter.

Ms. PORTER. Well, long-term care is very important to women because they are the ones who provide the majority of care giving.

And often women will leave the work force or give up a good deal of their time, their physical health, in order to do the care giving.

So I would say that the home- and community-based care is very important, and that we do have a full array of care.

As the President's plan includes only the assessment and the care plan, our concern is that there be some sort of guarantee beyond that, that the person gets the services that they need and that it is not just the basics and they get nothing further than that.

Chairman STARK. Thank you.

Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

Ms. Brown, I want to go back to page 2 in terms of the list of specifics that you have outlined in your key elements of health care reform. I need to know if what you say is what you mean. It says here, "A Federal guarantee that all individuals have access to affordable, high-quality health and long-term care."

That doesn't mean to me that the Federal Government guarantee coverage. When you say "access to guaranteed coverage" do you mean access?

Ms. BROWN. No, sir. We mean that they not only have access to it but they, in fact, do receive it.

One of the problems we are seeing now is in Florida—we just got a report the other day that the Area Agency on Aging has 20,000 requests that they cannot fill. So it is not to be——

Mr. THOMAS. OK. So it is guaranteed.

Again, farther down, you say, "Health delivery system reforms that increase access to care." So I guess there you don't really mean opportunity as the words "increased access" implies to me, but you mean guaranteed coverage as well.

Ms. BROWN. Yes, sir.

Mr. THOMAS. OK. Semantically you may want to change that to indicate that you want mandatory, guaranteed government offerings there, instead of "access to." In the terminology that we use, there is a world of difference.

Ms. BROWN. OK.

Mr. THOMAS. On pages 3 and 4 in your testimony, beginning on page 3, you indicate that you must have systemwide cost containment and universal coverage or you are not going to support the President's program.

It seems to me these go hand-in-hand, because why would you make all of those enormous cuts if you aren't going to get something for it? You want universal coverage and cost containment.

Let me ask you a more specific question. If you get the universal coverage and cost containment but the drug benefit portion and the long-term portion, because of costs or other reasons, gets dropped by the wayside in the process, do you believe your group would continue to support a plan? Can you support a plan that makes the Medicare, Medicaid cuts, provides universal access, and promises to reduce costs, but doesn't offer a significant or reasonable long-term care and drug program?

Ms. BROWN. First, just to comment about the cost containment, we believe that if there is not universal cost containment across all ages, that we are kidding ourselves and we will continue to have a shell game here.

Insofar as the drug proposal is concerned, our research as recent as 3 weeks ago indicates that among people of all ages—this is not just older people, but all ages—support for the bill drops dramatically if you take out drugs and/or long-term care.

The American public want that.

Mr. THOMAS. Would AARP oppose the plan if those were dropped?

Ms. BROWN. I cannot say what AARP would do. As you know, we have a process we would go through. We would be very loath to do that.

Mr. THOMAS. It would be required to reevaluate at the very least.

Ms. BROWN. Absolutely.

Mr. THOMAS. OK.

Ms. Porter, on page 1 you indicate that your organization welcomes President Clinton's health care reform proposal. And then in the next sentence you say: "We view the plan * * *"

Gee, I would like to have the copy that you have, if you have a specific plan and a proposal. You outlined the long-term care roller coaster in terms of what the task force thought it might do or might not do in terms of rumors. But then you went on and said that you were pleased with the final choice in the plan.

How can you make that statement? Do you know what is in the final plan?

Ms. PORTER. Well, just what was the outline of the plan that we all have seen.

Mr. THOMAS. So it may be subject to change.

Ms. PORTER. Yes, as I understand it.

Mr. THOMAS. OK. It was pretty declaratory, the way you presented it. I wanted to know if you knew something I didn't.

Ms. PORTER. No. Actually, in my written statement, it said we examined the plan that was dated September 7. So my remarks are based on that particular version.

Mr. THOMAS. Unfortunately, we are all operating off of dated material, and it may or may not be accurate.

Ms. McSTEEN, you indicated in your proposal on page 2, "Certainly, there is a lot of waste in the health care system."

The President's proposal tends to fund all of the changes in terms of the universal coverage, and the other structure, basically through removal of waste, fraud, and abuse in Medicare and Medicaid and a tobacco tax.

Do you believe there is that much waste, fraud, and abuse in the current Medicare and Medicaid structure to fund \$240 billion in other programs?

Ms. MCSTEEN. Well, of course it is very difficult to answer the question specifically because we don't know what the plan will really have of interest.

Mr. THOMAS. No, it is not a question of what the plan is. It is whether or not there is \$240 billion of waste, fraud, and abuse in Medicare and Medicaid.

Do you believe there is?

Ms. MCSTEEN. It has not been demonstrated.

Mr. THOMAS. OK. So if it can't be demonstrated and can't be found, the program can't be funded. That is exactly what the First Lady said.

Then, finally, on page 4, at the top of the page: "It is essential that Medicare beneficiaries, whether brought in under a Statewide plan or joins a health alliance voluntarily, is guaranteed the same level of benefits for the same cost as under Medicare."

Even if current Medicare recipients are subsidized and they are not paying the full cost of that medical care either in terms of de-

livery or in administration, would you like to maintain a subsidized structure?

Do you mean that we finally get Medicare on a real world cost, both in terms of administrative and cost of delivery, and then allow them to go either way?

Ms. MCSTEEN. Well, I think the coverage should be the same. And if there is inequity in the cost and it is not balanced, then we should look at it and raise questions about it.

Mr. THOMAS. Thank you very much.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

First let me thank all three of the witnesses not just for their testimony today but for the role that you have played for many years in bringing to the national attention the need for comprehensive health care reform.

You were very kind in your statements about what has been brought forward by this Congress and by this administration. But your organizations have played critical roles in sensitizing the need for health care reform.

I think all three of you have mentioned the problems with the differences between the Medicare program as suggested by President Clinton and what would be offered or required under the privately insured plans through the alliances.

There are different benefits, different deductibles, different rules for cost containment. And yet you appear reluctant to suggest—and some of you have opposed—Medicare being part of the health alliance.

I am wondering why you are reluctant to have Medicare part of the same system in which the privately insured marketplace will be. Same rules, therefore same cost containment rules, Medicare would not be discriminated against and would have the same benefits as the privately insured plans would.

Ms. MCSTEEN. Well, Medicare has been a very successful program for seniors. Of course, there are always concerns and room for improvements.

But it is a well-functioning program overall and it is the one national program that we can look to in terms of what the future might hold on a broad base.

What we have said is that we would like to see Medicare remain as is until we find that another type of plan, universal coverage, is in place and working, and then consider blending the two.

Mr. CARDIN. You have suggested changes in the benefit packages of Medicare. Let's talk about the administration of Medicare.

Are you satisfied by the way the claim forms are handled and Medicare is structured administratively?

Ms. MCSTEEN. There are very few people who would say yes to that. And we have all—I think most of us at the table here have been working with HCFA to make sure that the EOMB was changed. It is vastly improved.

But the redtape and the paperwork is excessive. No, we are not satisfied with that; but that is something that can be corrected if we put our minds to it.

Mr. CARDIN. And the cost shifting that takes place in which providers who handle a lot of seniors are discriminated against, are

you satisfied that that would not just continue under a system in which Medicare is separated from the great bulk of people's coverage?

Ms. MCSTEEN. Not with the focus on straightening it out. There has not been enough attention, and I think HCFA would admit that. To correct abuses, more money and attention is needed.

Mr. CARDIN. Ms. Brown.

Ms. BROWN. It does appear that, at the moment, about 65 cents is spent on Medicare patients for every dollar spent on private insurance patients.

So the divergence is great, and we are concerned.

Mr. CARDIN. So why not take the lead and be part of the same system that the privately insured employed marketplace would be part of?

Ms. BROWN. I think our major concern is that we have a program that is working, as Ms. McSteen has said, that is currently working; and it is working well. Older people are going to have, I think, a more difficult time relating to the new types of programs. They are not enrolled in HMOs in communities the way younger people are. And I think we might be biting off more than we can chew.

Mr. CARDIN. So we can take a risk for those people who are not eligible for Medicare, but those that are in the Medicare system we shouldn't change?

Ms. BROWN. No, I don't think we are saying that. I think we are saying that we want everyone to have opportunities for universal health care, but perhaps now is not the right time to make that change for Medicare. We would like——

Mr. CARDIN. Ms. Porter might be a little more friendly toward this.

Ms. PORTER. Well, as our members have indicated, that if we had a single-payer approach, then we would like to see Medicare integrated into a single-payer system.

However, under the proposed alliances or the President's plan, we are not sure of the ramifications of what it would mean if Medicare were integrated. So we would prefer, at least now, not to have it integrated.

Mr. CARDIN. I am not sure I understand that. Maybe we could expand a little bit more.

Under the single-payer plan, there is certainly many unanswered questions on how the delivery system is going to be organized. Yes, there is one payer; but we are not sure whether the delivery system will be through local plans or whether it will be through a national Medicare type plan.

So why are you reluctant to join the rest of us if we have a multiple-payer plan?

Ms. PORTER. The concept of the regional alliances are an untested ground in which we will be journeying forth. And we don't know what all of that means.

Whereas, with the single-payer approach we do have a model and we advocate for a single eligibility criterion and a single-tier system and we would see that the gamut of the age groups as well as the services could be met under a single-payer approach.

But we are just not sure with the President's approach.

Mr. CARDIN. But the model is not in America. I don't know which model you are referring to on a single-payer.

Ms. PORTER. Pardon?

Mr. CARDIN. The model being Medicare that you are referring to, what is the model? I didn't know we had a model on the single-payer.

Ms. PORTER. Well, the Canadian approach.

Mr. CARDIN. OK. Thank you.

Chairman STARK. Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman.

Ms. Brown, your organization—and I believe Ms. McSteen, your organization—has some problems with part B being based on income.

Could you further expand on your opposition to that portion of the proposal?

Ms. BROWN. Well, our concern with that, sir, is that it is only done with Medicare beneficiaries and not with everyone and that we would like to see that same kind of test for all individuals under health care reform, not only Medicare beneficiaries.

Mr. KLECZKA. OK.

Ms. McSteen.

Ms. MCSTEEN. That there would be a premium across the board and not just on seniors. It would be a matter of equity and fairness to make certain that everyone pays for whatever they receive.

And the part B premium would as it has been in the past, be continued. But the raising of the premium begins to cast doubt on how that really impacts on seniors individually.

Mr. KLECZKA. OK. But my assumption on the proposal is that high-income seniors will pay a bit more for part B versus those who are surviving on less income.

Ms. MCSTEEN. And if they go into an alliance it is assumed that they would also pay an additional amount. So that is where you have the trouble.

Mr. KLECZKA. OK, but the proposal wouldn't do both. Individuals wouldn't stay on Medicare and also get a policy with the alliance.

Ms. BROWN. But the issue is, will people who are not in Medicare also be required to pay the additional premium?

Anything that is done with seniors—

Mr. KLECZKA. Above and beyond the 20 percent we are reading about?

Ms. BROWN. Right. Our concern is it has got to be fair and equitable across all ages.

Mr. KLECZKA. OK. I understand that.

Chairman STARK. Will the gentleman yield?

Mr. KLECZKA. Sure.

Chairman STARK. If I could get a clarification, income relating, as I refer to it, the old catastrophic saw—as long as it is done for everyone, for a youngster like Mr. Kleczka, and old folks like me, and you in between—that as long as everybody pays something in relation to their income, you would not object for the seniors. It is just that if we only did it to the part B premium, for example, that you would object.

Am I restating that?

Ms. BROWN. The research with our members indicates to us that one of their major concerns is that the payment be fair and equitable across all ages.

Chairman STARK. Thank you for letting me clarify.

Mr. KLECZKA. Ms. Porter, your organization, in its testimony, basically is advocating more in most areas of what the President is proposing, a higher basic package, more subsidies for the low-income, things of that nature.

I don't see how your organization would pay for the extra benefits. In fact, my problem with the Clinton plan is I don't think his revenue measures will pay for his plan.

But what would your organization suggest to this committee and to the Congress as to what other revenue sources we could call upon to fund the package?

Ms. PORTER. Actually, I'm not prepared in terms of being able to go to some additional revenue sources.

I would be happy to draft something and submit it to you later. But I am not prepared right now in terms of where we could come up with some more.

But—our request was to talk about the strengths and weaknesses of the President's plan. And so we did look at the plan and look at where there were gaps. And these were among our recommendations—where we saw that there were some gaps in his plan.

And so we are responding to the committee—subcommittee's request.

Mr. KLECZKA. OK. But in viewing the President's plan as it was presented to us, do you believe that his funding mechanisms are sufficient to pay for the costs that he is advocating?

Ms. PORTER. Again, I don't have that expertise. I am reading what is in the paper and other estimates by the CBO and other entities that have that ability to do that. It is beyond my capacity.

Mr. KLECZKA. Well, if you could send something down to the Committee on how to pay for the additional benefits you are asking for, we would surely like to see those.

[Due to limited time and resources, Ms. Porter is unable to respond to Mr. Kleckza's request.]

Mr. KLECZKA. Last, in the statement from the National Committee—and let me quote from Ms. McSteen's testimony—"However, we are concerned that providing a government subsidy for 80 percent of the premiums would create a significant incentive to leave the job force."

This is the early retirement provision. "Reductions in contributions to the Social Security and Medicare trust funds could have a detrimental effect on the future of these funds."

This is one of my concerns with the plan. I totally agree with the statement. However, in the testimony, both OWL and AARP favor this portion of the bill, that is the early retirement age 55 to 64 provision.

Do your organizations share the concern that the National Committee has brought forth today?

Ms. BROWN. We have some concerns with that portion of the bill, and that is that people who do not have 40 quarters, notably older women, divorced women, will not get that benefit.

We could have a situation where a husband and wife divorce and the husband, because he is an early retiree, he is going to get the benefit and his wife and children are going to be sitting on the corner.

Mr. KLECZKA. OK. But the larger concern, I think, coming from the National Committee, which is so true, is that reductions in contributions to the Social Security Medicare trust funds could be impaired because you have more of the work force leaving, more of the contributors leaving.

Ms. BROWN. I don't—we will send you an answer to that. I don't think that our research is concerned with those numbers. But we will send you an answer to that, sir.

[The following was subsequently received:]

The administration estimates that between 350,000 and 600,000 individuals between the ages of 55 and 65 would take early retirement as a result of the President's proposal. While the loss of these workers would reduce Social Security and Medicare trust fund revenues in the short term, we understand that the "recapture" tax on employers who currently pay for retiree health benefits would flow into the trust funds to make up for the loss. In the long run, younger workers are likely to fill the jobs left by older workers, and they and their employers will then contribute to the trust funds.

Mr. KLECZKA. OK. As a person who has just received the AARP mailing to join, I am concerned with the early retiree provision. So I hope you would look at that.

I did throw it out, by the way.

Ms. Porter.

Ms. PORTER. As I understand, part of the reason for why the President's plan includes this provision is to provide protection for, in reality, those people that are in early retirement situations where they may be subject to either losing what their health care benefits are or their employers are finding it more difficult to cover it.

So this was put in as a means of protecting those people that are actually already in that situation or will be in the situation without estimating what would happen to their Social Security contributions.

But it is a reality that there are a number of people that are in that situation, between the ages of 55 and 65.

Mr. KLECZKA. Don't you believe that this policy, should it be adopted by Congress, would also provide for an incentive for people to retire early, not only covering those who are already moving out the door but for a middle executive looking at this?

The two concerns are, is there enough income to provide for the family until he or she gets Social Security at 65, and, health care. Once you provide for the health care, paid for 80 percent by the taxpayer, I think a lot more people are going to be looking more favorably in retiring early.

Ms. PORTER. I suppose that is a possibility, but there is still the part of the American work force that wants to continue working as long as possible.

We already have studies that we know people don't like to retire early, but just as well, incentives might persuade them to.

But as far as the American work force, studies indicate that they prefer to work as long as possible.

Mr. KLECZKA. Fine.

Thank you all very much.

Chairman STARK. Mr. Grandy.

Mr. GRANDY. Thank you, Mr. Chairman.

Ms. Porter, your organization is a signatory to the letter that I referred to in my opening remarks. Are they not?

Ms. PORTER. Yes, sir.

Mr. GRANDY. What is the name of this organization?

Ms. PORTER. Of our organization?

Mr. GRANDY. No. I know the name of your organization. I want to know the organization representing a broad range of American public that wrote this letter, which, by the way, has no letterhead.

Ms. PORTER. It is the organizations that have signed on to the letter.

Mr. GRANDY. But it is not—it is an ad hoc group; is it not?

Ms. PORTER. Yes.

Mr. GRANDY. So there is no executive director, there is no ongoing staff. I see.

Who wrote the letter?

Ms. PORTER. It originated with—I believe it probably originated with Citizen Action, as far as the first draft of the letter.

Mr. GRANDY. To your knowledge, did the White House have any role in preparing this letter?

Ms. PORTER. Not to my knowledge.

Mr. GRANDY. OK. Let me ask you about the assertion that you made in your first contention that basically says that because there is no requirement under the Cooper-Grandy bill that employers actually contribute a portion of the cost of health insurance for their employees, that individuals will then be unable to afford coverage and would continue to be uninsured.

Let me ask you then, if that is true, can you comment on the relative differences between the low-income assistance program in the Clinton bill and in the Cooper-Grandy legislation and why one is better than the other?

Ms. PORTER. Well, I must admit, I don't understand entirely how the low-income subsidies will work in the Clinton plan. And I think a lot of us have those questions, that we don't understand how the subsidies will work.

Mr. GRANDY. Well, that is a legitimate point, by the way, because a lot of us are still groping with what we know are the contentions but not necessarily the final details.

Let me just point out a couple of facts that might be interesting to your group. The Cooper-Grandy legislation provides low-income assistance to individuals and families up to 200 percent of the poverty level.

The President's proposal, at this point, such as it is, extends up to only 150 percent of poverty.

Second, the ability of individuals to deduct 100 percent of their premiums on the pooling arrangements will make coverage more affordable because that part not subsidized by the government would be deductible on your tax return.

Another point that I think is worth making is that the low-income assistance program in the bill that I am cosponsoring will cover 61 percent of the currently uninsured. And those are the people that are in greatest need. Of the total uninsured population, 27

percent fall between 200 percent of poverty and \$50,000 in annual income.

So you would have to presume that those individuals, if they were not buying insurance, were probably doing so partially because of their own choice.

The remaining 12 percent of the uninsured make over \$50,000. So the same thing would apply there.

Now, as you know, in both plans, there are insurance reforms which are common to almost every piece of health legislation. I would say that, at least in our bill, we are extending the same rights to coverage as the President has alleged but has not yet specified. In other words, regardless of health status, regardless of age, regardless of geographic location, regardless of sex, in other words, it is guaranteed issue.

I guess I would ask, again, knowing that, why is it necessarily true that individuals who would not necessarily have their employer pay 80 percent, or 50 percent, or something determined by the Federal Government, would be unable to acquire insurance?

Ms. PORTER. Well, speaking from the perspective of an advocate for women, we find that women are generally not well off in terms of the employment field. Women still are in low-paying jobs, they still are categorized into three occupational segments of the work force which—which will guarantee that they will continue to be low paying. They still are in the contingent work force either as part-time workers or temporary workers so that they are not able to pay for their own health care coverage.

Mr. GRANDY. Exactly the point. Exactly the point. If they can't pay, the government will subsidize. The differences between the Clinton plan and the bill that I am advocating is that we will subsidize more of those individuals up to a higher level. So the—particularly the uninsured woman who may or may not be in the workplace. As I read the details that we have that are constantly changing from the Clinton plan and the ones that are at least written into statute or into legislation, that I support, that gives that woman a greater access to health care.

Now I want to stress access and not mandatory coverage and that is a philosophical difference between the President's plan and ours. She would be empowered to a greater degree under this bill if she were low-income whether she were employed or not. If her employer paid a portion of the health care and she were still below the poverty level to the tune of 200 percent, the subsidized premium difference would aid her to acquire a plan. If she lost her job and had no coverage from the employer and was still below that poverty level, that voucher, that subsidy would increase.

So to some degree, the affordability and portability that we all talk about is specified in greater detail, which is why I find it, at best, inaccurate and, at most, dishonest to say that individuals unable to afford coverage would continue to be uninsured. Now, based on what I have told you, do you still believe that?

Ms. PORTER. Well, again, you mentioned yourself that you would cover 61 percent of the currently uninsured.

Mr. GRANDY. Yes. The ones that have no ability to pay. The question would be why would we cover people who are uninsured who

are very wealthy and could buy insurance without a premium subsidy? That is the point.

Ms. PORTER. And then the other 40 percent?

Mr. GRANDY. The other 40 percent are from 500 percent of poverty up to above \$50,000 in income, according to the models we use. You can contest those models, but that is something that usually we discuss when we have econometric bar graphs and charts before us. My point is this, you put a letter out to every Member of Congress, you have made assertions, and in your testimony you have not, at least, specified in detail why you think this particular comment is justified. I cannot find anything in your argument that supports this allegation, and I can find a lot in the materials that I provided to refute it.

Ms. PORTER. And I think maybe you hit upon something, too, yourself, in terms of saying that there is a difference between access and there is a difference between coverage and access. As far as the theoretical access to health care, because we all have access in theory in terms of that there are health services that are out there and there is a possibility of access to them. But do we have the means by which we have the services covered?

Mr. GRANDY. The means, that is exactly what you and I are talking about. My context is we provide the means, you acquire the coverage. That, I think, is an important component of all health care reform, and, to my knowledge, one that we have already specified in detail how people who do not have the means can acquire health care.

Ms. PORTER. I guess the other concern would be the extent of coverage in terms of—again, we would like to see the full gamut of services and that includes the long-term care that I have emphasized today. And that does not seem to be within the Cooper plan.

Mr. GRANDY. My time is expired.

Chairman STARK. Mrs. Johnson, would you pick up the cudgel.

Mrs. JOHNSON. Thank you, Mr. Chairman.

I would like to comment that most groups that we worked with are not willing to sign on to any plan yet. And so I really regret that the Older Women's League signed that letter. I don't think that there is a clear enough understanding yet of some of the issues for you to have done so and I hope to bring out one of those issues in 1 minute.

Let me just make some very brief comments before I go to my question. First of all, Mrs. McSteen, I appreciate the part of your testimony that pointed to some of your equity concerns for seniors under this system and I think that is very important.

And I would like to allude back to my colleague from Wisconsin's comment about the treatment of retirees. I think we all have to ask ourselves whether or not government should pick up the 80 percent cost of all retirees' premiums when, for low-income people, most of whom are women, we are only going to subsidize according to income. That kind of equity issue can't be washed over at this time. And I think we all are going to have to address it.

In terms of your testimony, Ms. Porter, I wanted to thank you for that portion which hasn't been brought out yet, where you specifically put OWL on record in support of family planning, pregnancy-related services including abortion services and counseling.

And I appreciate that. You didn't have to do that. Most of your members aren't interested in those services. But I commend you for that.

I would also ask you to provide me in writing some response to the CBO analysis of the single-payer system and how you, as a supporter of single-payer, think we are going to deal with the chart on page 9 of that report that shows that single-payer will increase costs more than it will reduce costs.

And I will be glad to show you those pages specifically. But I think you need to explain to folks like me why you are willing to go to single-payer when it will force us into volume controls that haven't been specified and what you think those volume controls will be.

[The following was subsequently received:]

CBO estimates that enactment of H.R. 1200 would raise national health expenditures at first but would reduce spending about 6 percent in 2003. The administrative savings from switching to a single payer system would offset some of the cost of the additional services demanded by consumers. Over the long run, the cap on the growth of the national health budget would hold the rate of growth of spending on covered services below the baseline.

In addition to reducing national health expenditures in the long run, a single payer system as delineated in H.R. 1200, would shift a large amount of health spending from the private to the public sector. The new program would assume virtually all spending now covered by private health insurance.

Mrs. JOHNSON. And then, last, I want to turn to a comment made in your testimony, Ms. Brown—but implied in all of your testimony—and that is the importance of systemwide cost control.

And I believe that is very important because if we don't control the costs, we will accomplish nothing. Because, in the end, access will continue to erode.

Now, in that regard, have your groups analyzed the impact of controlling costs through the global budget premium fixing scheme in the President's proposal?

And I would remind you that in that 239-page detail that we received, it actually does say that health alliances may provide, to the accountable health plans, their budget before the accountable health plans suggest a premium.

So it is very clear that the global budget is going to include Medicare; it is going to include a lot. Those are going to be deducted from the budget before it goes out to the States. So the States will know pretty much what these premiums are going to have to provide. And we are going to be able to divide by population into this budget, get a pretty clear idea what the premium will be.

The premium also won't just provide administrative costs for the insurer and health care reimbursement rates. Those premiums will now have to pay also for medical education. That has never been paid through the premium section. But 2 percent is going to be piled in there.

They are going to have to pay for the HIPC's administrative cost. That is another 2 percent. There are about five specific things that the premium is going to pay for they have never had to pay for.

So looking at that mechanism for premium setting and what it will end up covering and what it won't and looking at the more flexible mechanism that some of us support that will provide a similar kind of backstop—and that is limiting deductibility—and

let's, for conversation sake, assume we are going to limit deductibility to the value of the mean premium. Has your organization analyzed the impact of the global budget premium setting mechanism in the President's bill versus the deductibility approach which focuses competition in the center, forces those providing health care to compete to be efficient but doesn't set premium dollars behind it? Because this is true in the President's budget, every fee-for-service system in the President's proposal is going to operate by a fixed price system.

So have you looked at the relative impact of using deductibility as the pressure for systemwide control, a limit on deductibility, versus global budgets and premiums, and set premiums with price controls?

Ms. BROWN. I don't know that we have looked at that yet. We will get back to you on that.

[The following was subsequently received:]

With regard to the effectiveness of capping the health insurance exclusion, it should be kept in mind that such an approach does not directly limit health expenditures. It merely provides a disincentive to purchase more costly insurance by treating the amount of insurance above some threshold as taxable income. In short, individuals would pay higher income taxes under the "tax cap" approach. Estimates suggest, however, that a 10 percent increase in the price of health insurance reduces the consumption by only 2 percent. The disincentive would appear to be relatively weak. While a "tax cap" may have merit, it is not likely by itself to reduce costs.

Premium limits or ratesetting, on the other hand, would limit health expenditures directly. AARP generally supports the President's proposal to limit the growth in private insurance premiums. If done right, premium limits could protect individuals and families from high costs in a way that is easily understood and broadly effective. Premium limits in the private sector—with effective backup mechanisms to provide real enforceability—would finally begin to address cost growth where heretofore there has been no constraint on spending.

Ms. BROWN. We think that the premiums need to be set, and we agree with the global budgets. We also believe that these issues will have to be revisited as we work our way through the process.

And we are putting the onus on Congress to create—you know, the process that we go through in this country is rather laborious as we create new legislation, but we know that it works.

And so what we are looking to you to do is to create—and we are willing to work with you to try everything we can to help this happen—to create legislation which takes care of the women who cannot get health care; which provides wonderful things for children; which gives to families that are facing disability, whether they are young or they are old, these families are going broke; we are looking to you to lead us through the process to develop a health care reform system. We assume it will not be perfect. We assume we will have to revisit portions of it, but we are looking to you to do that for us. And we pledge to help you do that.

Ms. MCSTEEN. I think your question goes even further and raises the question that we are concerned about. And that is the effect of caps and global budgets on the quality of care.

And in this country we should not be thinking about whether we can afford to provide quality care; but how can we do it. And that is where the cost analysis would play a strong role.

Mrs. JOHNSON. Ms. Porter.

Ms. PORTER. No. That is all right.

Mrs. JOHNSON. Well, I do hope—actually, you hit the nail on the head, Ms. McSteen. If you have set caps and premiums—and I would ask you, Ms. Brown, to be rigorous in your analysis of this, and I hope you will all get back to me on this. I would be glad to sit down and talk to your groups about it, because if you limit deductibility to a mean premium, then you allow a lot more variation in approaches and particularly addressing quality issues.

And I would urge you—particularly all of you who have had experience with Medicare, you know perfectly well that when Medicare refuses to cover a drug, it affects quality. And we have done that in the past. But also by price fixing, very specifically, reimbursements for every activity, we have denied seniors access to care in my part of the country and are doing it increasingly.

I noticed that in one of your testimonies—actually in your testimony, Ms. Brown, you do say, “Medicare-only cuts increase the chance that physicians and other providers will not treat them.” And we are seeing that in Medicare, that cuts reduce access.

And fixed premiums—especially when the premiums are a function of a global budget that is already overloaded and is being forced down at a rate that is unrelated to costs—pose a very serious threat to America’s seniors.

And I would hope that you would work with me on looking at which is the best backstop which will preserve quality and flexibility out there.

If the mean—there is—you can’t go too far in diminishing service. So the competition will pull that mean down if the people can’t tolerate it. Whereas in the global budget, you will pull the mean down, whether it is realistic or not.

And we saw that in Medicaid. We are seeing that in Medicare and the VA system. My VA hospital in my district is such that if you need a hearing aid in central Connecticut, you go to New York City for the hearing test, even if you are 95.

So don’t think that global budgets don’t, over time, erode access and quality. Without question they do, and we have the models to prove it. So we can’t be too sanguine about somebody defining that global budget and then setting premiums.

And I hope you work with me on this larger issue. And that is one of the key things that lies behind this letter. And that is why I believe it was very unwise for any organizations to sign on that and not be able to answer to me why global budgets are better than tax deductibility.

Chairman STARK. Is there further inquiry?

Mr. THOMAS. Mr. Chairman.

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Just a brief question.

Ms. Porter, in your testimony you, once again, are fairly declaratory in terms of what is in the plan and stating what is in the plan, when most of us are still struggling with that 239-page general outline. We have seen statements that indicate that even what is in the 239-page outline is going to change, including testimony from some of the experts who helped put the plan together.

On page 1, you indicate that you are pleased with a number of items that are going to be offered. What I am trying to do is just get a feel for tradeoffs.

Any package that passes—and I believe a package will pass—is going to be a very difficult thing to put together politically.

One of the areas the administration has decided to include in the package is family and reproductive services. I don't know exactly what that means and it can go all the way from \$1.95 counseling to complete services for voluntary abortions. The political scale from one to the other is enormous.

So the question I would ask you is, if everything that you know about the plan—which seems to be more than we know about the plan—if everything you know about the plan remains the same but the family reproductive services portion does not include abortion coverage, if that was dropped from the plan, would that change your position of supporting or opposing the plan?

Ms. PORTER. Well, I guess I wear two hats in a sense, because I am here as representing the Older Women's League; but, as I also indicated, and it is indicated in my testimony, that we have convened a coalition of women's organizations called the Campaign for Women's Health. This service is very important to the campaign. So as—

Mr. THOMAS. I have no question that it is important. But in the political problem of trying to pass a comprehensive program that will reform a \$1 trillion segment of the economy, significantly restructure a number of professions and businesses, change, in part, the relationship between the patient and the doctor, I asked you a hard question. But I would like to have an answer.

If the abortion portion is not in it, would that change your position of supporting the plan to opposing?

Ms. PORTER. Again, with my dual nature, I would say probably as representing the Older Women's League, that we would not go down in flames over whether or not it was in there.

But as far as representing the Campaign for Women's Health, I think that would be another matter.

Mr. THOMAS. I am trying to test the waters.

You are saying that there are some groups who would be willing to scrap the entire project if it didn't include reproductive services, including the costs of abortion in that basic benefits package?

Ms. PORTER. Yes, there were some groups that feel strongly enough.

Mr. THOMAS. OK. And I am trying to get it from a point of view of a political problem. I am not trying to indicate a plus or minus for you, since we just had a vote yesterday on the floor, you know, surrounding that issue. It is going to make it that much more difficult to carry whatever we carry across the line.

Ms. Brown, Ms. McSteen, do either of you have a feeling about it? If the costs of abortion were dropped from the plan, would that change the AARP's position in support or opposition for the plan?

Ms. BROWN. Practically not.

Mr. THOMAS. Probably not.

Ms. MCSTEEN. No.

Mr. THOMAS. You are looking at it, in relative terms, in terms of the overall program?

Ms. BROWN. Yes. You have to understand, though, that AARP has a process that we would go through, and I may be wrong.

Mr. THOMAS. I understand that. But also the clientele of both of you is significantly different than part of the coalition that Ms. Porter represents. Some people are dealing with this in a theoretical sense; others are dealing with it in a real world sense. And I understand the difference.

Thank you.

Chairman STARK. Mrs. Johnson, I have been informed that our colleague would like to yield to you.

Mrs. Johnson is recognized for a brief clarifying question.

Mrs. JOHNSON. Thank you.

I did want to ask, if, in polling your constituencies, you have been careful to define what long-term care benefit the President is actually offering and to make clear that this is not a nursing home benefit, that this is only a slightly enriched home care benefit that is slightly enriched over the current Medicare benefit?

I mean even a lot of seniors in my district who won't be able to qualify as severely disabled will not get an enriched home care benefit under this plan.

And I wonder—I want to be sure that in your polling and support that your people are really understanding what is being offered and what is not being offered in the President's plan.

Have you been specific in dealing with your folks about this?

Ms. BROWN. From the AARP, I believe we have. We have held forums around the country. And at those forums, we have had people available to answer questions on those issues.

Mrs. JOHNSON. Have they made a point, though, to try and educate?

Ms. BROWN. Yes. You know, we all face the same issue. And the same issue is: How do we get enough information that is good out to our constituents so that they truly understand?

And that is your problem, and we all face the same problem: How can we educate the public as to what it is that is being proposed so that they can knowledgeably get answers?

I believe we have done a good job so far; but, of course, we don't have a whole plan, and it is a difficult task.

Ms. MCSTEEN. It is really very difficult to get people to understand, as you pointed out. But we continue to try.

But until we have some, what I consider real, examples, I think we will not get our message across. We will just have to see, with the various pieces of legislation, how we can best present the issues; we are awaiting the administration's plan before we decide.

Ms. PORTER. OK. We are a smaller organization than either of the two on either side of me, so we do have, probably, the opportunity to reach all of our members, because we are a smaller organization.

And we have made it clear in terms of what the long-term care provisions are. And our charge from our members is that we try to get as much of long-term care services as we can. And this is what we hope to do with the hearings, is to see what we can do better on long-term care than is already currently in the President's plan.

Mrs. JOHNSON. Thank you.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Thank you, Mr. Chairman.

While we are discussing prioritization, let me just ask you quickly—you may not be in a position to respond at this moment and, tactically, it might not be wise—but let me probe in terms of your membership.

Do you have any feel as to whether, in terms of priorities they would put prescription drug or home health care provisions above one another?

Ms. MCSTEEN. We do not have at this time. But what we are anticipating having is some precise figures, that is, what the deductible will be for the prescription drug benefit. And if there will be a premium for long-term care.

And then I think we have an opportunity to say, if you can have one or the other, this is what you would get and what you would pay for in both respects, and then get the answer.

Mr. LEVIN. So right now, in terms of your organization, there is a need for more detail about each of the two?

Ms. MCSTEEN. You are correct.

Mr. LEVIN. Fair enough.

Either of you want to respond?

Ms. PORTER. It is—it is a hard situation to make a choice, in terms of which one would be ranked above the other. I don't know. I couldn't say.

I think they are both so equally important that I couldn't rank them.

Ms. BROWN. As far as AARP is concerned, if there is no long-term care portion to the bill, we are unable to support anything that would do that.

We also feel that it is equally important to have a drug piece. And our research, as recently as 3 weeks ago, of all ages of Americans, said that, without those two pieces, the support for the bill goes down. And it is a dramatic change.

We can provide you with that information. We are always doing polling.

[The following was subsequently received:]

The inclusion of long-term care and prescription drugs in health care reform is critical to older Americans' support for reform.

Prescription drugs. The combined effects of high pharmaceutical prices and the lack of Medicare coverage for prescription drugs have significantly limited access to needed drug therapies for older Americans. A recent national survey sponsored by AARP showed that:

- older Americans use significantly more prescription drugs than other age groups to maintain their health;
- prescription drug insurance coverage declines rapidly as age increases; and
- out-of-pocket costs for prescription drugs are significantly higher for older Americans than for their younger counterparts.

As a result, many older Americans cannot afford the prescription drugs they need and are denied access to essential, often life-saving, medications—compromising their health status and making them more likely to receive unnecessary and more expensive acute care. Many more compromise their prescription instructions, thereby reducing their efficacy and increasing the likelihood of higher acute care costs.

Long-term care. A survey conducted for AARP this past April found that 90 percent of the respondents felt that including long-term care in a health reform proposal was important. Support for health care reform increased from 46 to 82 percent when long-term care was included. More recently, in a poll conducted for AARP in October 1993, 86 percent of respondents in California stated that they would be less in favor of the President's health care proposal if it included no coverage for long-term care.

According to a survey conducted in the fall of 1991 by DYG, Inc., three-fourths of Americans (18 and older) were "very concerned" about paying for the cost of long-term care. The concern, which is felt sharply by both men and women, extends to all income and age groups. In fact, concern about long-term care was greatest among persons age 50 to 64—those most likely to be caring for older parents and worrying about their own futures.

In a Harris survey conducted during December 1992 and January 1993, 91 percent of the respondents said they could not afford long-term care when they were told it would cost \$15,000 to \$60,000 a year, or \$40 to \$160 a day. With regard to a Federal program providing long-term care in the home for the chronically ill or disabled, over 80 percent of respondents favored such a program not only for people 65 years of age and older, but for adults and children as well.

Mr. LEVIN. When you say long-term care, the President's proposal, as you have seen it, you would define that as long-term care?

Ms. BROWN. Well, it is obviously not a dream—our dream definition of it. But it is a beginning, sir. And we recognize there are two major issues for older people. One is they need and want to stay in their homes as long as they can.

And, second of all, they dread going into a nursing home and going broke and leaving the spouses not in the nursing home going broke.

Although it is not perfect, we would like to be sure that it is shored up so that there is adequate care health care. But we are willing to make a start there.

Mr. LEVIN. As long as there is an important beginning, is that a fair assessment of your position?

All right.

Thank you very much, Mr. Chairman.

Chairman STARK. Thank you. I had one final question. I am a little puzzled about the alliances. The more I look at it, the more I wonder what they do and, if we didn't have them, whether we couldn't still go ahead and do all the things that everybody wants to do, either directly or through other existing agencies.

And so I just ask each of you, how you feel about the alliance, the State-operated type. I will give you three choices, just to make it easier: Do you feel they are absolutely essential; do you dislike them; or are you indifferent?

Ms. Brown.

Ms. BROWN. I guess I am unwilling to answer that because I am not sure that I am comfortable with what the offshoot would be if you didn't have them.

So I am unwilling to answer that.

Chairman STARK. Let me ask you this: Do you know, would it make any difference, the way we run Medicare or the way we run private insurance or anything else?

I am not against them. But I don't know—

Ms. Porter.

Ms. BROWN. They appear to be a mechanism for a start.

Ms. PORTER. Well, again, to reiterate, our preference is for the single-payer approach of, you know—

Chairman STARK. Mine, too.

Ms. PORTER [continuing]. Of health care reform. But given the President's plan, we are sort of like you, asking how is it going to work and trying to understand it. But at least with the President's plan, it appears to be the mechanism by which we will get health reform. It is a means of getting health reform. And I think that is

something to keep in mind, too, not have the small steps, the incremental steps, but true comprehensive health reform.

So it does seem to be the structure by which we would have it.

But, again, our preference is for a single-payer approach.

Chairman STARK. I just say to you that the Federal Government could do whatever the alliance is going to do and say everybody's mad.

There are a lot of organizations—the Congress, the President, HCFA—that could do this.

Ms. McSteen.

Ms. MCSTEEN. Well, the health alliances raises questions that we are all waiting for. How much power will they have; how much money will they have; how fair will they be to all of their membership; what the competition will be. Those are questions we are still asking.

Chairman STARK. What I would say in response is that Medicare goes on with its warts and blemishes, as Ms. McSteen has pointed out; but it has gone on all these years, without alliances, quite well.

And I just say how would you improve Medicare by creating alliances?

I don't know that you would. I am not suggesting the rest of the President's plan couldn't be put into action. Is this some objection to alliances and the power they might get on the part of insurance companies?

There was some concern expressed about this in the Senate yesterday. I would postulate the President's plan could proceed unimpeded. Just don't include the alliances.

Thank you very much. We appreciate your participation, and we hope that it will be ongoing. I would say on behalf of all the members of the committee, we would like to be kept abreast of what your membership tells you through your polling and how your various organizations react to the changes of the plans that will come forward.

Don't wait for the next hearing to let us know, because that will help us in our deliberation.

Thank you very much.

The next panel, representing the consumers groups, will consist of Gail Shearer, manager of policy analysis, Consumers Union, and no stranger to the subcommittee; Stan Dorn, managing attorney, National Health Law Program, Inc.; Rebecca Cain, president, League of Women Voters of the United States; and Richard Kirsch, executive director, Citizen Action, New York, representing Citizen Action in action.

Welcome to the panel.

We will ask, Gail, if you would like to lead off.

STATEMENT OF GAIL SHEARER, MANAGER, POLICY ANALYSIS, CONSUMERS UNION

Ms. SHEARER. Thank you, Chairman Stark.

Consumers Union appreciates the opportunity to present our views on the Clinton administration's proposal for health care reform. Consumers Union's efforts in support of health care reform,

like those of Chairman Stark and many committee members, goes back many years.

Today I brought along with me a copy of the February 1939 issue of *Consumer Reports*, and I would like to share with you something that we said. This is over 50 years—

Chairman STARK. I am probably the only person here that subscribed then.

Ms. SHEARER. Our 1939 article concluded, "It has become obvious that the people of the country intend to see to it that the whole population shall benefit from the discoveries of modern medical science. The only question before the country now is 'how soon?'" It is time for us to finally end the Nation's health care nightmare and answer the question "now." Consumers cannot and should not have to wait longer for a solution to the health care crisis.

Consumers Union is eager to help you analyze the element of reform from the consumer perspective. As your subcommittee helps lead the Congress' consideration of the reform plan, we urge you to also stay in touch with the average American consumer, the people whose lives are either improved by a health care system that works well or whose lives are destroyed by a health care system that fails them.

Only by keeping in touch with these consumers will the Congress be able to stand up to the many special interests that will seek to make their case in order to develop a health care program that meets consumers' expectations and need for health care reform.

To meet the needs for consumers, any health care reform plan must offer: Universal quality health care, with comprehensive benefits; cost containment; fair share financing; public accountability; and consumer choice of health care providers.

While we continue to believe that a single-payer health care system as incorporated in H.R. 1200, also known as the McDermott bill, could best meet the health care needs of American consumers, we are pleased that the Clinton administration has embraced many of these principles. We believe that the Clinton proposal would move the Nation's consumers closer to health care security. Still, it leaves room for significant improvements.

The strongest part of the health care plan is its commitment to universal health care protection. The Nation can no longer rely on the free market and wishful thinking when it comes to health care security. Health care is not a commodity like detergent or VCRs that can be bought and sold in the marketplace. While the free market works well for things we buy at Kmart, it utterly fails when it comes to surgery, checkups, and other health care services.

The proposal, if enacted, would offer relief to the millions of Americans who are now denied protection due to their financial status or to preexisting conditions. I plan to briefly summarize Consumers Union's five-five plan, five ways to improve the Clinton health care proposal and five elements that must be protected in the face of special interest opposition.

First, the Clinton health care proposal makes a good start at providing consumers with health care security. The following five changes would make it even better.

First, the plan should be changed to protect low- and middle-income consumers from paying a disproportionately high share of

health care costs. And the best way to do this is to cap the employee's contribution at 2 percent of income.

Second, it must encourage the State single-payer option. The Clinton proposal allows States to establish a single-payer system, but it includes a provision that seems to discourage them from doing so. We think that the State single-payer option should not merely be tolerated but should be encouraged, because the single-payer option has the best chance of meeting consumers' needs. And in States that do not elect a single-payer option, it is essential that the health plans be made accountable to consumers, not insurance companies' shareholders.

Third, make freedom of choice provider a real option for people of all income levels by requiring all health alliances to offer a fee-for-service plan that costs little more than the average cost plan. This change is needed because freedom of choice—freedom to choose health care providers is one of the most highly valued features that consumers seek in health care reform.

Fourth, include the blueprint for phasing in nursing home benefits and expanded community care benefits. We recognize, as should Congress, that these benefits will require a substantial new funding base; and we recommend that you consider increasing taxes to pay for the expanded long-term care benefits.

Fifth, give the National Health Board the authority to regulate prescription drug prices that apply to all Americans, not just the Medicare and Medicaid eligible. When it comes to the regulation of prescription drug prices, we believe the administration plan should be strengthened, to include the authority to regulate drug prices. If drug prices were a river, they would already be well above flood stage. It is meaningless to talk about voluntary price controls, since prices are already out of line.

This month's issue of Consumer Reports, which we will provide to every Member of Congress, provides very strong evidence for the need for expanded regulation of prescription drug prices.

Mr. THOMAS. Excuse me. How much is it?

Ms. SHEARER. Pardon me?

Mr. THOMAS. How much does it cost?

Ms. SHEARER. \$2.95.

Mr. THOMAS. OK. That will qualify.

Ms. SHEARER. Under the limits. OK.

Mr. THOMAS. Thank you.

Ms. SHEARER. Every element of the Clinton health care profession will be subject to attack from a variety of special interests.

We urge you to carefully consider the interests of the average American consumer in preserving these important elements of health care reform:

First, universality must be a reality by 1997. It should not be dependent on voluntary participation or cost savings.

Second, both public and private spending must be subject to stringent cost containment, both to achieve savings and to avoid cost shifting.

Third, the number of employees needed to form a corporate alliance should not be expanded beyond 5,000.

Fourth, the most severely injured victims of medical malpractice must be protected.

And, fifth, the benefits package must remain comprehensive.

This is what consumers want and need, and it is crucial to avoid a burgeoning supplemental market and a multitiered health care system.

Thank you.

[The prepared statement and attachment follow:]

**TESTIMONY OF GAIL SHEARER
MANAGER, POLICY ANALYSIS, CONSUMERS UNION**

Consumers Union¹ appreciates the opportunity to present our views on the Clinton Administration's proposal for health care reform. Consumers Union's efforts in support of health care reform -- like those of Chairman Stark and many Committee members-- go back many years. In 1939, Consumer Reports noted that forty million Americans received inadequate medical care and called for enactment of the Wagner National Health Bill, which would have been a "cornerstone for a national health program."² In 1946, Consumer Reports supported the Wagner-Murray-Dingell Bill, which would have established federal compulsory health insurance.³ In 1975, Consumer Reports published a comprehensive comparison of five proposals for national health insurance and established five goals that a national health insurance plan must meet to serve the consumer interest. Consumer Reports published a two-part series, "The Crisis in Health Insurance" in 1990, and a three-part series in 1993 that reviewed wasted medical care dollars, consumer satisfaction with Health Maintenance Organizations, and solutions to the health care crisis.

In 1939 -- over fifty years ago -- our article concluded: "It has become obvious that the people of the country intend to see to it that the whole population shall benefit from the discoveries of modern medical science. The only question before the country now is 'how soon?'" It is time for us to finally end the nation's health care nightmare and answer this question "now!" Consumers can not and should not have to wait longer for a solution to the health care crisis.

Consumers Union is eager to help you to analyze elements of reform from the consumer perspective. As your Subcommittee helps lead the Congress's consideration of the reform plan, we urge you to also keep in touch with average American consumers -- the people whose lives are either improved by a health care system that works well, or whose lives are destroyed by a health care system that fails them. In developing its health reform proposal, the Clinton Administration was successful in reaching out to the consumers who are on the receiving -- or non-receiving -- end of health care in America.

Only by keeping in touch with these consumers will the Congress be able to stand up to the many special interests that will seek to make their case, in order to develop a health care program that meets consumers' expectations and needs for health care reform.

CONSUMER PRINCIPLES FOR HEALTH CARE REFORM

To meet the needs of consumers, any health care reform plan must offer:

¹Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide consumers with information, education and counsel about goods, services, health, and personal finance; and to initiate and cooperate with individual and group efforts to maintain and enhance the quality of life for consumers. Consumers Union's income is solely derived from the sale of Consumer Reports, its other publications and from noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports with approximately 5 million paid circulation, regularly, carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

²"The Wagner Bill and Mr. Gannett," Consumer Reports, April 1939, p. 20 and "By Popular Demand," Consumer Reports, February 1939, p. 32.

³"Bureaucracy in Medicine?," Consumer Reports, April 1946, pp.

universal, quality health care (with comprehensive benefits) for all U.S. residents -- regardless of age, income, employment status or health status);

cost containment with a national health care budget and control over wasteful paperwork and procedures;

fair-share financing with savings from cost containment as a central funding source and additional funding obtained on a fair and equitable basis;

public accountability with consumers well represented on all boards overseeing health care; and

consumer choice giving consumers the freedom to choose where they will go for health care and who will provide it.

While we continue to believe that a single-payer health care system as embodied in H.R. 1200 could best meet the health care needs of American consumers, we are pleased that the Clinton Administration has embraced many of these principles. We believe that the Clinton proposal would move the nation's consumers closer to health care security. Still, it leaves room for significant improvements.

THE CLINTON HEALTH CARE REFORM PLAN A CONSUMER PERSPECTIVE

We have evaluated the Administration's draft health care reform plan (dated September 7, 1993) against the five consumer principles listed above. Attached to this testimony is our analysis (including a summary). The strongest part of the health plan is its commitment to **universal health care protection**. The nation can no longer rely on the "free market" and wishful thinking when it comes to health care security. The proposal -- if enacted -- would offer relief to the millions of Americans who are now denied protection due to their financial status or to pre-existing conditions. The plan offers security to everybody against unforeseen events such as development of serious illness or loss of jobs.

The Clinton health care proposal incorporates elements that we have long supported, including (1) a standard, comprehensive benefit package for all Americans; (2) control over health care premiums set by the National Health Board, rather than the free market; (3) a prohibition of balance billing, and (4) rejection of caps on damages for victims of medical malpractice. The attached analysis explores in more detail both the strengths and the weaknesses of the Clinton proposal.

In the remainder of my written testimony, I will summarize our comments by presenting five areas where we believe the plan needs to be strengthened, as well as five components that must be defended against attack and erosion from special interests.

FIVE WAYS TO STRENGTHEN THE CLINTON HEALTH CARE PROPOSAL

The Clinton health care proposal makes a good start at providing consumers with health care security. The following five changes would make it even better at meeting consumers' needs and expectations for health care reform.

- 1. Protect low- and middle- income consumers from paying a disproportionately high share of health care costs.**

While all employers are assured of not having to pay more than 7.9 percent of their payroll cost for health insurance premiums, individuals and families are offered no such protection by the draft proposal. We believe that the employee's share of the premium (which is proposed to be 20 percent of the weighted average

plus any amount of premium exceeding the average) should be capped at about 2 percent of income for plans that cost less than (or equal to) the average. Without such a cap, low wage workers who are not eligible for a subsidy could face a very steep burden, especially if they want the freedom to choose their own doctor. In addition to limiting premiums as a percent of income, we recommend that you consider reducing the cost-sharing requirements in the low cost-sharing plan to ensure that deductibles and coinsurance requirements do not serve as a barrier to health care for anybody in this country.

2. Encourage the state single payer option.

The Clinton Administration health care proposal allows states to establish a **single-payer** health care system, but includes a provision that seems to discourage states from doing so. It would require that states appropriate revenue from "sources other than those established by this Act" to pay for the program. It is not clear to us what this means, but its direction is wrong.

Does it preclude a state from imposing a payroll tax, one of the provisions of most single-payer legislation? In light of the ability of a single-payer system to achieve the principles of universality, cost containment, accountability to consumers, freedom to choose providers, and fair financing, the federal government should affirmatively provide the necessary funding to states to encourage them to adopt a single payer health care system.

3. Make freedom-of-choice of provider a real option for people of all income levels by requiring all health alliances to offer a fee-for-service plan that costs little more than the average cost plan.

Freedom to choose their health care provider is one of the most highly valued features that consumers seek in their health care system. Consumers want to be able to continue long-standing relationships with their family doctors, specialists, pediatricians, and other health care providers. Often, one family will have an array of doctors, making it impossible to follow them all to one HMO. Consumers want to be assured that if serious illness strikes, they will have access to the highest-quality specialist and specialized treatment centers.

All consumers -- even those that can afford the fee-for-service option -- face considerable uncertainty about whether their current doctors will be available to them. We are concerned about the possibility that freedom of choice of provider could be a luxury only the rich can afford. We recommend that in negotiating for a fee-for-service health plan, health alliances should be required to make this option available to all, by limiting the premium differentials (above the average cost plan) that can be charged by fee-for-service plans.

4. Include the blueprint for phasing-in nursing home benefits and expanded community care benefits.

The United States faces a growing long-term care crisis that will only get more severe as the population ages. Consumers Union has concluded that the private insurance market is incapable of solving the nation's long-term care problem -- it will never cover people who can not afford the high premiums, nor will it protect people whose pre-existing conditions make them uninsurable. The draft health plan includes an important community based care benefit. But the requirement that potential beneficiaries must be unable to perform three "activities of daily living" limits the benefit to a small portion of people in need of long-term care. For example, a person incapable of moving around (e.g., from bed to a chair) and unable to go to the bathroom by herself can not be left home alone all day long, but may not qualify for the new

community-based benefit.

Consumers Union supports including in the health plan a blueprint for future expansion of public long-term care benefits, including both expanded community based care and nursing home care. We recognize -- as should the Congress -- that these benefits will require a substantial new funding base, and we recommend that you consider increasing estate taxes (possibly by taxing capital gains at death), charging premiums for persons with incomes above a certain level, and increasing income taxes, and/or payroll taxes.

5. **Give the National Health Board the authority to regulate prescription drug prices that apply to all Americans, not just the Medicare- and Medicaid-eligible.**

The Administration's draft plan has several provisions that will help to keep prescription drug prices in check. The National Health Board, for example, can make public declarations regarding the reasonableness of launch prices for new drugs and can study and report on the reasonableness of drug prices. In addition, rebates of at least 15 percent of the average manufacturer price are required for drugs issued through Medicare and Medicaid. We believe the plan needs to go further. The United States is the only industrialized country that makes no effort to regulate drug prices, forcing U.S. consumers to pay higher prices to help pay for research that benefits citizens of other countries, who pay much lower prices. The Office of Technology Assessment recently reported that during the 1980's, pharmaceutical companies on average earned about 15 to 30 percent more profit than was needed to attract adequate investment capital. We strongly recommend that the National Health Board's responsibilities include the authority to regulate prescription drug prices.

FIVE PROVISIONS TO FIGHT TO KEEP

Every element of the Clinton health care provision will be subject to attack from a variety of special interests. We have identified five areas where we believe the consumer interest lies in keeping the provisions that are in the draft plan. We urge you to carefully consider the interests of the average American consumer in preserving these important elements of health care reform.

1. **Universal health care must be a reality by 1997.**

Extending universality to all Americans must NOT be dependent on achieving cost savings and must not be phased-in with a vague timetable. Universality must be a reality by 1997. The plan must resist attempts to make the employer responsibility **voluntary** or participation in health alliances **voluntary**. The level playing field for all employers and the end to cream-skimming by health insurers are critically needed elements in the plan.

2. **Cost containment through limits on public and private spending must be kept.**

Global budgets and premium caps to curb cost growth in both the public and private sector health spending are essential. The plan appropriately includes curbs on health care spending, and this backstop protection should not be sacrificed to give the failed "free market" cost containment efforts yet another chance to drive up health care costs. Also, Congress must guard against health care provider pressure to abandon the ban on balance billing and physician self-referral. These are two culprits that have contributed to today's high costs. You also must resist all efforts to grant antitrust exemptions (beyond the guidelines in the draft plan) for doctors, hospitals, and pharmaceutical companies.

3. Keep most large employers in the system.

The draft plan would allow employers with more than 5000 workers to operate in a separate "corporate alliance" system, presumably with a tax of one percent or so to help pay for research that benefits everyone in the country. The "corporate alliance" system should NOT be expanded by reducing the minimum 5000 worker level, because to do so would undercut the goal of achieving a universal system that treats all Americans the same and would contribute to a multi-tier system. The tax on corporate alliances should be preserved and set at a fair level: not only does it help pay some of the costs and subsidies of the system, but it helps decrease the incentive for large employers to opt-out of the system, reducing the "tiering" of health care. It is crucial that corporate alliances be required to offer the standard benefits package and be subject to the same set of rules that apply to health plans in regional alliances.

4. Protect the victims of medical malpractice.

It is vital that consumers most severely injured by doctor negligence be fairly compensated; there should NOT be any caps on malpractice awards for pain and suffering.

Contrary to the mythology that has evolved around the medical malpractice problem, malpractice premiums account for a very small portion of health care costs -- only about one percent. The Congressional Budget Office recently concluded that changes in the medical malpractice liability system would have a small impact on national health expenditures, and they therefore declined to "score" any savings. Goals of medical malpractice reform should be to identify and discipline doctors guilty of repeated medical malpractice, and to increase the ability of the system to fairly compensate malpractice victims.

5. Keep the benefits package comprehensive.

One of the strengths of the Clinton Administration health care reform package is the comprehensiveness of the benefits package, including a range of benefits such as prescription drugs, some long-term care benefits, and mental health benefits. The benefits package must not be whittled away, or else the concept of universal protection and security will be compromised, and a burgeoning supplemental market will develop and help perpetuate a multi-tiered health care system.

Thank you very much for the opportunity to testify today. We look forward to working with your Subcommittee as this important debate continues.



Publisher of Consumer Reports

THE CLINTON HEALTH CARE PLAN: A CONSUMER PERSPECTIVE

Like any proposal that contemplates dramatic change of a major industry, the President's health care proposal is not without serious flaws which we would like to modify. Consumers Union's comments and recommendations revolve around the five principles for health care reform that we embrace:

- universal access to comprehensive benefits
- cost containment
- fair financing
- accountability to consumers
- freedom to choose providers.

Consumer Principle: Universal Access to Comprehensive Benefits

The strongest element of the proposal is that it extends universal health care protection to all Americans. It would end the tragic suffering faced by millions of people who are now denied adequate care because they are excluded from the health insurance market due to financial barriers or pre-existing conditions. The benefit package is comprehensive, and includes building blocks for long-term care. The proposal would put an end to insidious insurance company practices such as exclusions of pre-existing conditions, waiting periods, underwriting of high risks, and pricing practices that charge higher premiums for higher risks. Each eligible person would receive a health security card that would open the door to health benefits.

However, Consumers Union believes that the proposal perpetuates a multi-tiered health care system, with differentiation between populations such as the Medicare-eligible, the Medicaid-eligible, early retirees, corporate health alliance participants, regional health alliance participants, and military personnel. Different budget constraints apply to different segments of the population. The proposal should be strengthened by establishing a goal (within a timetable of five years) of working toward full integration of the entire population into a uniform system for everybody. Undocumented workers and their families should have full access to the uniform health care system since the plan specifically requires premiums to be paid for these workers. Instead of differentiation between groups, there should be benefit parity in all segments (Medicare, Medicaid, regional alliances, etc.). We believe that health care reform will serve consumers better — and will have broader public appeal — if there is the perception and the reality that everybody is in this together. Indeed, consumers want a

Washington Office

1656 Connecticut Avenue, Suite 310 • Washington, D.C. 20009-1039 • (202) 462-6262

This release may be used for legitimate purposes only. Use of material from Consumers Union for advertising or other purposes is prohibited.

♻️ 100% Recycled • 15% Post Consumer Waste • Soy Inks

system that provides uniform benefits regardless of age, income, health status, or employment status.

While the benefit package is comprehensive, there is one key area where expanded benefits should be included: long-term care. Even with a better-functioning private market, the private insurance market will not be able to solve the nation's long-term care problem. While the plan makes a good start by expanding community health benefits, eventually the benefits should be expanded to lower the activity of daily living (ADL) requirement for community based care and to allow for public financing of long-term nursing home care.

One of our health reform goals is to sever the link between employment and health care coverage. While the proposal does make coverage portable for most consumers, the employer and family/individual premiums are based on employment status, not income. Unlike an income-based finance structure (which can be achieved through a proportional payroll tax), the financing link to employment status (e.g., full-time, part-time, retiree, corporate alliance, etc.) creates inequities (e.g., between part-time vs. full-time workers, early retirees vs. senior workers). These inequities will make the plan unaffordable for many low-income consumers, forcing them to cut corners for basic necessities such as food and shelter in order to pay for their health care premium. The addition of an income cap would alleviate many of these problems just as the payroll cap will alleviate much of the burden on small low-wage businesses. (See the financing section below).

Regulations affecting the supplementary insurance market need improvement. First, there is no justification to allow the continued sale of low-value hospital indemnity insurance and dread disease insurance: these products should be banned outright. Consumer Reports has repeatedly concluded that these products are an essentially worthless purchase. Second, regulations and standardization should apply to the supplemental market for benefits, not only the supplemental market for cost-sharing. The supplemental market should consist of a limited number of (e.g., three to five) standard policies, and these policies should be subject to a loss ratio of 80 to 90 percent. Employers could offer these packages (premiums would be subject to taxation) or individuals could purchase these packages on their own with no underwriting or pre-existing condition exclusions. Benefits (packaged from a low to a high benefit package) could include: full dental coverage, full mental health coverage, expanded home care protection, full nursing home coverage, and unnecessary cosmetic surgery. Without these provisions, the supplemental market is likely to be characterized by confusion (as policies vary considerably) and low value products.

With regard to the comprehensive benefits package, it is important that the plan eliminate ambiguity as to whether health plans will be allowed to offer benefits beyond the guaranteed benefit package: health plans should be prohibited from including extra benefits in the basic package. Insurance companies have a long history of adding bells and whistles to policies that confuse consumers and enable them to charge unjustifiably higher premiums. If plans were allowed to add on extra benefits, the standardization that creates administrative simplicity and improves consumer comparison shopping would be compromised severely.

Whether the guaranteed benefit package is truly comprehensive depends in large part on how health plans under tight budget constraints interpret the coverage; consumers need protection against stingy interpretations that could result in denial of needed care (see the section below on accountability to consumers.)

Summary of Recommendations: Universal Access to Comprehensive Benefits

1. The proposal should establish a five-year goal of full integration of all populations (e.g., regional alliance enrollees, Medicare population, Medicaid population) into a uniform system for all, with identical benefits and choices.
2. The benefit package should be expanded (with an appropriate phase-in schedule) to include home care benefits with a less severe disability requirement and to include an expanded public program that phases in the funding.
3. Low-value policies no longer needed, such as hospital indemnity policies and dread disease policies, should be prohibited from being sold.
4. The supplemental insurance market for extra benefits (e.g., additional dental care, additional mental health benefits) should be subject to standardization (e.g., three to five standard policies) and should be subject to loss ratios of 80 to 90 percent. Supplementary policies should be community rated, and no underwriting or pre-existing condition exclusions should be allowed.
5. The proposal should be clarified to explicitly prohibit health plans from adding benefits to the comprehensive benefits package, unless the additional benefits are offered in a separately priced standard supplemental policy.

Consumer Principle: Cost Containment

Consumers Union is a strong supporter of global budgeting for health care expenses, because we view global budgets as the only sure way to rein in exploding health care costs. We welcome the fact that the Administration is making a very serious effort to curb the health cost spiral through a national health care budget. We endorse several elements of the plan that will curb spending: the national health care budget, constraining the growth of Medicare and Medicaid, banning self-referrals, establishment (by each regional alliance) of fee schedules for the fee-for-service component of health plans, and the prohibition of balance billing in excess

of fee schedules in the fee-for-service plan.

One of our concerns relates to the fact that the health care system will consist of many different segments. The differentiation leads to the need to treat different segments with different schedules and different sets of rules. We recognize that the plan builds in a .9% differential -- added allowed growth -- in the Medicare and Medicaid budgets. Growth in Medicare has been substantially greater than private health care growth -- by a differential of about 4 percent. We question whether the .9% differential will be adequate to correct the past inequities that have led Medicaid, in particular, to be a second-rate, lower quality portion of the nation's health care system. And we fear that if the .9 percent differential is too low, that Medicare will follow in the footsteps of Medicaid in delivering inferior care to senior and disabled citizens. Only by integrating the entire health system into a uniform system can there be assurance that everybody is treated fairly.

A second concern relates to the role of insurance companies -- which are accountable primarily to their shareholders -- in implementing the budget austerity called for by the plan. It is true that consumers can vote with their feet in the long term by joining a different health plan. But, when it comes to health care, short term considerations can have life and death implications. Switching health plans does little good if the reforms result in five or fewer competing health plans, with oligopolistic pricing and across-the-board low quality.

In your proposal, health plans whose premium bids exceed the target are assessed a penalty if an alliance's weighted average premium exceeds its premium target; this will lead to strong incentives for plans to keep downward pressure on their premium. This downward pressure is positive to the extent that health plans curb administrative costs, but we are concerned about undesirable effects if it leads insurance companies to deny legitimate claims, cut back too far in servicing their policy holders' needs, or over-expanding its review of provider's treatment decisions. We fear that hundreds of insurance companies, each with its own protocols, will interfere increasingly with doctors' clinical judgments. These are problems inherent in any system that retains a major role for private insurers. The best way to achieve true budget discipline is by establishing a single payer accountable solely to the American consumer -- this would assure that all consumers and providers are treated fairly and equitably.

Regulation of prescription drug prices needs to be strengthened. The responsibilities of the committee of the National Health Board should be stepped up to include broad authority to regulate prescription drug prices. First, the Board should conduct an analysis of prescription drug pricing, comparing prices of identical drugs in the U.S. with prices in other countries. The Board should review the excessive profits that drug companies have made on drugs that were discovered in part because of federally-financed research. Voluntary cost containment -- that limits growth of already grossly excessive drug prices -- is insufficient. In many cases, price rollbacks would be appropriate. The concept of the rebate (equal to at least 15 percent of average manufacturer price) for certain drugs that applies to the Medicare and Medicaid drug benefit should be expanded to all covered prescription drugs. Cost savings should be achieved across the board, not just for drugs covered under Medicare or Medicaid.

The National Health Board should study ways to broaden the principle of global budgeting to include health costs that are not included in the initial budget: supplemental benefits, health components of workers compensation and automobile insurance, premiums for cost-sharing benefits, long-term care benefits that are outside the package, and any other health expenses.

We have grave doubts that competition in the health care marketplace in reality can serve the consumer interest. We also question whether the marketplace will operate competitively or whether the new collaboration between formerly competing providers and a more highly concentrated insurance market will serve to maintain or raise prices as a result of oligopolistic pricing practices. We strongly support the proposed repeal of the McCarran-Ferguson antitrust exemption. We urge the plan to carefully spell out that Department of Justice and Federal Trade Commission guidelines called for in the plan are intended to minimize protected activities and maximize competition in this marketplace.

Summary of Recommendations: Cost Containment

1. Set the goal of an integrated global budget within a time period of five years that includes spending under an integrated benefit system and includes all national health care spending, to enable the system to treat all segments of the population fairly regardless of the cause or timing of the injury or illness.
2. Treatment protocols should be developed and generated by doctors and hospitals through a centralized system, not by utilization review companies that are accountable individually to hundreds of insurance companies. Increased use of outcomes research should be used to develop uniform treatment protocols.
3. The National Health Board should have broad authority to regulate drug prices, including price rollbacks and manufacturer rebates that would apply not only to Medicare and Medicaid prescription drugs, but to all covered prescription drugs.
4. The legislation should explicitly provide that the Department of Justice and Federal Trade Commission minimize safe harbor exemptions from the antitrust laws and maximize healthy competition in the health care marketplace.

Consumer Principle: Fair Financing

Consumers Union believes that the best way to finance health care reform is through income-related payroll taxes, income taxes and excise taxes on tobacco, alcohol, and firearms. Because the proposed financing does not embrace this principle, it creates inequities and fails to generate sufficient revenue to achieve the level of benefits and subsidization we believe is needed. Adding a cap on the individual/family premium (as percent of income) would be an important step toward solving most of these problems.

The principle source of funding for the proposal is a premium-based employer mandate, with reasonable limits on the percent of payroll that employers must pay. The proposal includes subsidies for low-wage employers, significantly easing the burden on these businesses. Individuals and families are responsible for 20 percent of the premium plus any additional premiums resulting from plans whose costs exceed the average as well as premiums for supplemental policies.

One of our major concerns is the proposal's lack of symmetry when it comes to capping employer AND employee premium contribution. We believe that the employee's share of the premium (which is proposed to be 20 percent of the weighted average plus any amount of premium exceeding the average) should be capped at about 2 percent of income. Without such a cap, low wage workers who are not eligible for a subsidy (i.e., those with incomes above 250% of poverty) could face a very steep burden, especially if they want the freedom to choose their own doctor. A single mother who works full-time, for example, could be responsible for a premium of \$900 on a \$2500 policy, when the weighted average premium is \$2000 and the employer contribution is \$1600, 4.5% of a \$20,000 income, an unreasonable burden for a low-income family. She would pay coinsurance and deductibles on top of the premium costs.

Under the proposal, part-time workers are responsible for a share larger than 20 percent of the weighted average premium because the employer share is prorated. A 15-hour-a-week low-wage worker will be liable for 60 percent of the premium (with 40 percent paid by the employer). It is not clear to us whether this must be paid even if the part-time worker's spouse is employed. If so, this would put a very steep burden on the family. In any case, part-time workers' premium payments should be capped as a percent of income, just as others' would be.

The proposal includes a windfall for early retirees and their employers: a subsidy (from the rest of the system's participants) for people who retire between ages 55 and 65. While we recognize that this segment of the population is in need of access to health insurance at affordable prices, we do not believe this substantial redirection of health care dollars is advisable. This problem points once again to the preferred way to finance health care -- through income-related taxes. It does not make sense to require low-wage workers to face premium costs of 5 percent or more of their income (on top of their employer's contribution) while early retirees, some of whom have substantial income, are responsible ONLY for the family/individual

premium portion. We need a system where everyone is treated the same, not a patchwork system that results in inequities.

We believe that it is appropriate to ask the Medicare-eligible population to help pay the cost of new prescription drug and long-term care benefits, through an increase in the Part B premium to cover 25 percent of the new benefit cost. Without this type of provision, seniors for the most part would receive a new benefit without having the opportunity to pay for it during their working years. However, the higher premium would represent a burden on lower-income seniors. We recommend that lower-income seniors (up to about 150 percent of poverty) be exempt from the premium increase, paying for this adjustment by increasing the proportion of the drug cost that would be paid by other seniors to perhaps 35 or 40 percent.

Summary of Recommendations: Fair Financing

1. Replace the mandated employer premiums with an income-related payroll tax, excluding the first \$10,000 of income, eliminating inequities among two-worker/one-worker families, part-time employees, and early retirees.
2. Cap the family and individual premium payments (for the average cost policy) at 2 percent of income. (Allow this to be exceeded if the employee buys a higher-than-average-cost policy).
3. Ease the burden on low-wage workers by requiring employers to pay the individual/family share (20%) of the premium for employees with incomes up to 250% of poverty. (Employer contributions would still be subject to the overall caps).
4. To pay for the additional subsidies, for additional benefits such as long-term care, and for creation of parity between different programs (Medicare/Medicaid/regional alliances), impose an income surtax, a tax on new hospital revenues that are created by reduced spending for uncompensated care, and a tax on corporate alliances.
5. Exempt the lowest-income senior citizens (up to about 150 percent of poverty) from the increase in the Part B Medicare premium, increasing the amount paid by other seniors to cover 35 to 40 percent of the new prescription drug benefit. (The goal would be to have total new premiums pay for 25 percent of the new benefit).

Consumer Principle: Accountability to Consumers

In theory, the creation of health alliances as consumer purchasing cooperatives increases the accountability of the health care system to American consumers. The make-up of health alliance boards, with membership balanced between consumers and employers, not providers and insurers, is an important component of this accountability.

Our biggest concern in this area is the **major role that will be played by insurance companies** in implementing the new system. How, for example, will insurance companies cut costs in order to live within the budget constraints? Unfortunately, we cannot assume that insurance companies will always cut the "right" costs -- administrative waste, unnecessary care, and red tape. They will have a strong incentive to cut needed health care services as well. We also fear that they will each use their own individual treatment protocols, their own utilization review companies, and will interfere with doctors' treatment decisions.

The health care system needs more outcomes research and needs protocol for weeding out the \$130 billion wasted each year on unnecessary care. But we question whether this can be done fairly and efficiently through hundreds or thousands of individual for-profit entities, rather than through a single entity accountable only to the public.

The National Health Board is charged with awesome responsibilities that will determine the quality of the health care system and its ability to constrain costs. It is critical that the selection criteria for members assure the appointment of the most qualified people who are committed to serving the interests of consumers.

The proposal allows states to establish a **single-payer health care system**, but includes a provision that seems to discourage states from doing so. It would require that states appropriate revenue from "sources other than those established by this Act" to pay for the program. Does this provision preclude a state from imposing a payroll tax, one of the provisions of most single-payer legislation? In light of the ability of a single-payer system to achieve the principles of universality, cost containment, accountability to consumers, freedom to choose providers, and fair financing, the federal government should provide the necessary funding to states to **encourage** them to adopt a single payer health care system.

We are pleased that the **medical malpractice proposals** in the plan would not cap damages received by the victims of medical negligence. Additionally, we applaud the provision allowing consumers to obtain information concerning doctors who commit repeated acts of malpractice. Providing this important information will help consumers make a **meaningful** choice of doctors. We are concerned that the award will be reduced by any amount obtained from collateral sources after a finding of malpractice. While we do not believe in double recovery, we do think that the wrongdoer should pay, not be subsidized by the victim's insurance policies. Malpractice premiums should be experience-rated; caps on lawyers' fees should apply to lawyers on both sides, and to avoid conflict-of-interests, alternate dispute

resolution mechanisms should be conducted within the health alliance, not within individual health plans.

Summary Recommendations: Accountability to Consumers

1. Make the state single-payer option a real alternative by encouraging states to exercise this option through federal assistance, providing the necessary funding.
2. Increase accountability of insurance companies/health plans to consumers by placing requirements on insurance company/health plan boards of directors. At least half of the board members should represent consumer interests and have no financial stake in the profitability of the company. Insurance company executives' salaries (i.e. total compensation) should be open to public review and scrutiny.
3. In appointing members to the National Health Board, both the President and the Congress should carefully review each candidate's commitment to the quality of the health care system (while allowing for a willingness to improve the system).
4. Medical malpractice premiums for providers should be experience-rated, so that the vast number of doctors who provide excellent care are rewarded by lower premiums and the few doctors who provide substandard care are penalized by higher premiums.
5. Caps on lawyer fees that are imposed on lawyers representing medical malpractice victims should also be imposed on defense lawyers.
6. Practice guidelines should not be used to shield doctors who commit malpractice.
7. The Alternative Dispute Resolution System should function at the Alliance level, not at the health plan level because of the conflict of interest that a health plan has in any malpractice situation.

Consumer Principle: Freedom to Choose Providers

Freedom to choose their own health care provider is one of the most highly valued features that consumers seek in their health care system. Consumers want to be able to continue long-standing relationships with their family doctors, specialists, pediatricians, and other health care providers. Often, one family will have an array of doctors, making it impossible to follow them all to one HMO. Consumers want to be assured that if serious illness strikes, they will have access to the highest-quality specialist and specialized treatment centers.

The proposal recognizes the strength of consumer sentiment on this important attribute by requiring that each health alliance includes at least one fee-for-service plan. (States can ask the National Health Board for a waiver from this requirement in very limited circumstances). In most regional alliances, consumers will be able to choose from a low cost-sharing plan (presumably in an HMO with virtually no ability to go outside the HMO for non-emergency medical care), a high cost-sharing plan (apparently with freedom to go to a fee-for-service doctor) and a combination plan, with most care delivered within an HMO or network, but freedom to go outside of the network for medical care with higher cost-sharing requirements.

While this proposal does indeed provide most consumers with some flexibility, we fear that many low- and middle- income consumers will not be able to afford to pay considerably higher premiums that could be associated with fee-for-service plans. Without some constraint on premium differentials between fee-for-service and HMO-types of plans, freedom of choice of provider could be a luxury only the rich can afford. Health alliances should take steps to assure that competition among health plans is based primarily on quality, not price. In negotiating for a fee-for-service health plan, health alliances should address this concern and consider ways to make this option available to all, by limiting premium differentials to about 10 percent, by requiring employers to pay the individual/family 20-percent-premium-share for employees with incomes up to 250 percent of poverty (thus making them better able to afford the fee-for-service option if they want it), and other options. Again, the plan should facilitate the creation of single payer health care systems, which preserve the freedom of provider for all consumers, through start-up grants.

Under this proposal, consumers face considerable uncertainty about whether their **current doctors** will be available to them -- even if the consumer chooses a fee-for-service option. It is impossible for anyone to predict which of their doctors will join which HMO and whether all of the doctors will be available in the same HMO. In order to allay concerns for this transition to a new system, we recommend that consumers enrolled in a fee-for-service plan should be allowed to continue to see their present doctors, even if any of these doctors sign up to work in an HMO or physician network that is not a part of the consumer's fee-for-service plan, during a transition period to be determined by the regional alliance.

Another concern is that a consumer will sign up for the low-cost-sharing (HMO) option in the beginning of the year (when healthy), and will regret this **inflexibility if a serious illness strikes**. In the long-run (annual open enrollment), the consumer will be able to switch to a more flexible health plan. We believe that in the event of serious new illness or dissatisfaction with treatment provided, some flexibility to go outside of a low cost-sharing health plan should be allowed. Under this proposal, plans should be allowed to recapture increased costs (or lost revenues from higher "combination" cost-sharing) through retroactive premium adjustments from individuals and families who exercise this option.

Summary Recommendations: Freedom to Choose Providers

1. During the transition period, consumers who enroll in a fee-for-service plan should be allowed to see their current physicians, even if these doctors are enrolled in an HMO or other provider network outside of the fee-for-service plan.
2. Health alliances should assure that a fee-for-service option is accessible to all consumers, e.g., by imposing a 10 percent premium differential (over the average premium plan) for a fee-for-service plan, or by requiring employers to pay the family/individual share of premium for employees at less than 250 percent of poverty.
3. In the event that serious illness strikes or questions of quality arise, consumers enrolled in a low-cost sharing plan should be allowed to seek treatment outside of the plan (paying the higher cost-sharing amounts), until they can switch out of the plan during open enrollment.
4. The National Health Board should facilitate the state adoption of a single payer system through provision of necessary funding.

Chairman STARK. Mr. Dorn.

**STATEMENT OF STAN DORN, MANAGING ATTORNEY,
NATIONAL HEALTH LAW PROGRAM, INC.**

Mr. DORN. Good morning, Mr. Chairman, members of the subcommittee.

The National Health Law Program is the legal services national backup center that specializes in health care issues affecting low-income people. We work with legal aid programs all around the country trying to help them get essential health care for their low-income clients.

And it is quite an honor to testify this morning before you, Mr. Chairman, and before the subcommittee. We very much appreciate your efforts, through the years, to make sure that everyone, not just those with means, can purchase health insurance.

And we particularly appreciate your remarks this morning, specifically directed to the needs of underserved populations. It is quite an honor to be here.

One of the nice features of life in Washington, D.C., is that we have access to international restaurants, offering dishes that combine ingredients in strange and novel ways, sweet and sour flavors, often combined in a single dish.

The President's health care reform plan, likewise, has its sweet ingredients and its sour ingredients. And this morning I would like to discuss both with respect to four issues of particular importance to low-income consumers: First, mainstreaming low-income people into the same health plans that serve middle class folks; second, the issue of quality; third, the issue of affordability; and, finally, the issue of Medicaid benefits.

First of all, in terms of mainstreaming, one of the positive features of the President's plan is that it has features intended to permit low-income consumers to choose the same health plans that serve middle class folks.

Plans are paid the same reimbursement amounts for Medicaid beneficiaries as for others, and the subsidies attempt to enable low-income people to enroll in plans up to the regional average.

Unfortunately, Mr. Chairman, as you noted in your remarks, some of the affordable provisions in the plan endanger the ability of these positive provisions to meet their objectives, because low-income folks may have no choice but to pick the plan offering the cheapest out-of-pocket costs.

And, in addition, depending on the civil rights protections in the plan, it is unclear whether the kind of redlining you outlined this morning may occur. So there is potential here. We will have to wait for the legislation to see whether it is achieved.

The second issue is quality. And under the President's plan, we would shift to a system of managed care, where the plans are paid the same amount per consumer, regardless of how much care is provided. That means the less care the plan provides, the more money the plan makes. And as the GAO noted, this creates an incentive for underservice; this creates a need for strong consumer protections.

And again it is unclear from the plan how strong they will be. The framework seems to be there for consumer protections. But I

can tell you, as someone who works with Medicaid recipients around the country who have been put in managed care plans in ever-increasing numbers in recent years, it is a serious issue you need to pay attention to.

Let me give you just one example of what can happen to folks in the absence of consumer protections. A 51-year-old Medicaid recipient in Los Angeles with a history of hypertension experienced chest pains and swelling of her joints. She called her managed care plan, which gave her an appointment in 9 months. A short while later, her child came down with a 104 °F temperature, and the child was given an appointment, 2 months in the future.

Finally, the woman went outside her managed care plan to a private doctor who said she was in danger of a heart attack and her child was also experiencing severe health problems.

We get examples like this constantly from around the country. So what you need to keep an eye on, as the plan makes its way to Congress—hopefully sometime soon—I would ask a couple of questions. One is, will the legislation direct the National Health Board to develop strong, quantified standards for all health plans?

Second, will the standards be enforceable by private people aggrieved and by others?

Third, will plans be required to collect detailed data showing what is actually being provided to consumers?

Fourth, will plans be required to extend notice and appeal rights to patients who are denied care or who have care delayed?

And, finally, will standards regulate financial risk arrangements within plans, which really have an enormous potential to determine whether that gatekeeper can do an honest job or is going to be affected by financial personal incentives?

The third issue I would like to discuss is affordability. The late representative Claude Pepper once explained, "For the elderly poor, a 50 cent copayment, which seems insignificant to most of us, can mean the difference between a needed prescription and a quart of milk or a loaf of bread." We can only imagine what he would have said about the administration's proposal that \$5 copayments, not 50 cent copayments, should be applied to the elderly poor and to other low-income people, \$10 copayments for physician visits, and a staggering \$25 copayment for mental health visits.

Low-income people asked to make these payments will delay seeking health care until their health problems degenerate into emergencies. And by that time, many will suffer harm, and we will incur unnecessary emergency room costs. This is a feature of the plan that we think needs major improvement.

The final issue I would like to address is the issue of Medicaid benefits. And one of the concerns we have with the President's plan is that important Medicaid benefits are—seem to be eliminated for many Medicaid recipients.

I will give you just a few examples. Others are in my statement.

One is the issue, again, of mental health services where people who are severely mentally ill right now in many States have access to services as needed.

Under the President's plan, after 30 outpatient visits, you don't get any more outpatient visits. For folks who are seriously men-

tally ill, it is just not enough. They are going to lose essential benefits.

A second example: Disabled people, adults and children, who need rehabilitation services to prevent deterioration in function, those services are covered quite often now. They won't have those services covered under the President's plan.

A final example would be low-income adults who need dental services or eyeglasses for employment. Most Medicaid programs provide those benefits right now. And they wouldn't any more under the President's plan.

Now we hear these last two issues are on the table in the administration, and they are up for grabs. And if you folks want to weigh in on that, we would be delighted. But if the plan reaches the Hill in the form that we saw in the September 7 draft, improvements will need to be made.

In short, Mr. Chairman, sweet and sour tastes may do very well in restaurant reviews; but when it comes to health care policy, we hope very much that you will keep the sweet and improve the sour.

[The prepared statement follows:]

**TESTIMONY OF STAN DORN
MANAGING ATTORNEY, NATIONAL HEALTH LAW PROGRAM, INC.**

Good morning, Chairman Stark and members of the Subcommittee. I am Stan Dorn, Managing Attorney at the National Health Law Program, the legal services national back-up center that specializes in health care for low-income people. We work with hundreds of legal services programs around the country that try to help their indigent clients obtain the basic necessities of life, including health care. It is an honor to testify this morning about consumer issues and national health care reform before some of the Congress' most distinguished champions of consumer rights.

One nice feature of Washington is its abundance of interesting, international restaurants, often featuring dishes with striking combinations of sweet and sour tastes. The Administration's proposed health care plan likewise has its sweet and sour ingredients. This morning, I would like to discuss both sides of the Administration's September 7 draft plan, focusing on four issues that are important to low-income consumers: mainstreaming low-income people into the same health plans that serve middle-class consumers; assuring that managed care is quality care; making coverage both universal and affordable; and ensuring that we do not finance health care reform by cutting back on current, essential coverage for the most vulnerable members of our community -- Medicaid beneficiaries who are both poor and sick.

1. **Low-income consumers should have the opportunity to choose the same systems of health care that serve middle-class consumers.** One of the positive features of the President's September 7 draft plan is that it attempts to give low-income consumers access to the same health care systems that will serve middle-class people. It provides that health plans will receive the same basic amount for Medicaid beneficiaries as for other consumers. It also permits low-income people, whether or not they have Medicaid coverage, to enroll in any health plan up to the regional average price. These are critically important measures to prevent low-income consumers from being segregated into inferior and distinct health care plans, segregation that often would be both economic and racial. As I will mention in a few moments, however, these positive measures could fail to achieve their objective unless the Administration's bill does a better job of making health care affordable to low-income consumers.

2. **The expansion of managed care should be accompanied by strong systems of consumer protection.** Years ago, workers descending into the coal mines always brought along canaries, who are very sensitive to poisonous gas leaks. When the canaries fainted or died, the miners knew it was time to leave. Mr. Chairman, Medicaid beneficiaries have been America's canaries in the mine of managed care. Enrollment in Medicaid managed care nearly doubled between 1987 and 1992.¹ During Fiscal Year 1992 alone, Medicaid enrollment in managed care increased by 35%, reaching 12% of all Medicaid beneficiaries.² The experiences of these low-income consumers illustrate the need for strong consumer protections to safeguard quality of care.

¹GAO/HRD-93-46, MEDICAID: States Turn to Managed Care to Improve Access and Control Costs (March 17, 1993) p. 4.

²HHS News (Nov. 30, 1992) p. 1.

Managed care dramatically reverses the incentives affecting the health care industry. As the GAO noted, "While fee-for-service payments give providers incentives to provide too many services, capitation payments give providers incentives to provide too few services."³ Without strong consumer protections, this incentive to underserve can create serious harm.

For example, in California, special Primary Care Case Management systems ("PCCMs") have been carefully designed to slip through the loopholes in state and federal managed care regulations.⁴ Without protections, the Medicaid consumers in these plans have often suffered grave harm. For example:

- A 51 year old woman in Los Angeles with a history of severe hypertension suffered from chest pains and swollen joints. She could not get an appointment with her provider for nine months. In the meantime, her four-year old son suffered a febrile seizure, with a 104-degree temperature. The managed care plan offered only an appointment more than two months away. Finally, the mother and her son went outside their managed care plan to a private doctor, who found that the mother was at grave risk of heart attack and that the child needed immediate treatment.

- In San Bernadino, California, a PCCM routinely disenrolls consumers brought into the County's trauma care center. While this neatly excuses the PCCM from paying for expensive treatment, it has forced patients to go without coverage for thirty days or more while their status is changed to fee-for-service. This has left many patients unable to obtain critical follow-up care, such as skin graft clinic follow-ups for burn victims.

- In Fresno, California, one legal services advocate reports that, of thirty PCCM families in her caseload, only one has been able to see a doctor. The rest have been deterred by six to seven hour waits at clinic offices and the absence of transportation to a clinic as far as twenty miles from the patients' homes.

Many think of California as a trend-setting state, often for the better, but sometimes for the worse. Unfortunately, in this case, these California stories about Medicaid managed care typify those we hear from legal services advocates all over the country.

Fortunately, the Administration's plan proposes a framework for strong consumer protection. Under the September 7 draft, the National Health Board will develop core quality and performance measures and consumer survey questions, including those directed to underserved populations and consumers changing health plans; national goals and minimum

³GAO/HRD-93-46, supra.

⁴The Medicaid quality protections in 42 U.S.C. 1396b(m)(2)(A) apply only to capitated plans furnishing either inpatient care and one other service described in 42 U.S.C. 1396d(a)(2), (3), (4), (5) or (7) or three such outpatient services. PCCMs provide one or two such services and abstain from covering inpatient hospital care, thereby evading federal protections. They are also exempt from California's requirements under the state's Waxman-Duffy and Knox-Keene acts.

performance standards on selected quality measures; and conditions of participation required of health plans. Further, states will be required to certify health plans. This framework may well provide essential protections, depending on what is in the September 7 legislation. Here are a few key questions to keep in mind when the legislation arrives at the Congress:

- Will the legislation direct the National Health Board to develop strong, quantified standards for all health plans? Such standards might govern, e.g., travel and waiting times for care, the percentage of children receiving age-appropriate immunizations, and the percentage of pregnant women receiving prenatal care during the first trimester, including for underserved populations.

- Will these standards be enforceable? For example, will aggrieved consumers have a right to sue, with access to all proven remedies? Will plans that violate these standards be barred from enrolling new consumers until violations have been corrected? When consumers become ill because of inadequate care and change health plans, will the plans they leave be required to continue paying for care until the illness concludes?

- Will plans be required to collect detailed data on utilization, available for analysis by diagnosis code and patient characteristics like age, race and sex? Will data collection also include information on waiting times and length of visit for primary care and specialty referrals? Will data collection use nationally compatible forms needed to cross-tabulate and compare key information? Will such information, without patient-identifying information, be publicly available?

- Will health plans be required to extend notice and independent appeal rights to patients who request services that are delayed or denied? Will such rights include access to out-of-plan second opinions? Will expedited appeals to neutral third parties be available in urgent care situations?

- Will standards regulate financial risk arrangements within plans? For example, will plans be forbidden from giving primary care "gatekeepers" personal, financial incentives to deny referrals to specialty care?

Many have already characterized the National Health Board as an unnecessary and harmful new bureaucracy. Mr. Chairman, if you want to stop people from making money in ways that cause harm — whether you're talking about bank robbery or denial of necessary health care -- you need someone to specify what's illegal, someone to detect wrongdoing, and someone to punish it. To paraphrase Winston Churchill, bureaucracies like police departments and courts, or the National Health Board, are the worst method of protecting the public from dangerous profiteering -- except for all the other methods.

3. Coverage should be both universal and affordable. Perhaps the most important positive feature of the Administration's plan is that it provides nearly universal coverage, guaranteeing that people who suffer economic misfortune or illness will nevertheless keep their

health coverage. Under alternative proposals before the Congress, this is not the case. Some proposals, for example, will not provide health security until after substantial cost savings have been achieved in Medicare and Medicaid.

For low-income consumers, universal coverage will only be meaningful if it is affordable. Unfortunately, the September 7 draft presents extremely serious problems in this area. The very poorest people in our community will be required to make the same co-payments asked of middle-class people enrolling in HMOs. As the late Rep. Claude Pepper once explained,

"For the elderly poor, a fifty cent co-payment which seems insignificant to most of us can mean the difference between a needed prescription and a quart of milk or a loaf of bread. What right do we have to ask them to make this choice?"⁵

We can only imagine what Rep. Pepper would have said about the September 7 draft's proposed co-payments of \$5, not fifty cents, per prescription, \$10 per doctor visit, and \$25 per mental health visit for the elderly poor and other low-income people. For the average non-poor family, the equivalent co-payments would be \$37 per doctor visit; \$18 per prescription; and \$92 per mental health visit.⁶ Such co-payments force low-income people to defer care until health problems degenerate into emergencies. The result: their health is endangered, and emergency room costs increase needlessly.

One Rand Corporation study found that co-payments applied to poor people increased overall health care costs, as fewer people saw doctors, and more ended up in the hospital.⁷ Another Rand study found that, while middle-class people's health may not have suffered from copays, significant co-payments for low-income people with heart disease increased short-term risk of death by 10%.⁸ The President has proposed that we move away from high-cost emergency care towards low-cost primary care -- but the co-payments proposed in the September 7 draft prevent the achievement of that goal for low-income people.

These issues of affordability also interfere with a second important goal of the President's plan: a single health care delivery system for all. Without strong protections for low-income

⁵House Select Committee on Aging, Comm. Pub. No. 96-181 (1979), p.28.

⁶Committee on Ways and Means, U.S. House of Representatives, Overview of Entitlement Programs: 1993 Green Book Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means (July 7, 1993) p. 1214, showing that, in 1991, the mean income, per family member, in non-poor families was 3.67 times that in poor families.

⁷Helms, et al., "Copayments and the Demand for Medical Care: The California Experience," 9 *Bell J. of Econ.* 1 (1978), finding that, in 1972, \$1 Medicaid copays for the first two physician visits a month decreased physician visits by 8%, increased inpatient hospital use by 17%, and increased overall program costs between 3-8%. Although fifteen years old, this is the only study of which we are aware that analyzes overall program costs and savings caused by imposing across-the-board primary care copays specifically on an indigent population.

⁸Brook, et al., "Does Free Care Improve Adults' Health?" 309 *New England J. of Med.* (Dec. 8, 1983), 1426, 1431, 1433 (Table 8).

people, both in terms of premiums and co-payments, the poor will have no choice but to pick the health plan promising the lowest costs, even if that changes from year to year. The result may be a distinct tier of health plans for the poor providing inferior quality care, segregated along racial and economic lines.

To avoid these problems, we suggest two changes to the September 7 draft plan: co-payments for low-income consumers should be limited to the nominal co-payments permitted under Medicaid, and eliminated for very low-income consumers (e.g., those with incomes below the federal poverty line); and premiums should be capped as a percentage of household income, which should decline in lower income brackets and be forbidden for the very poor, much as small employers have a premium cap that declines with company size and worker income.

4. We should not finance health care reform by denying currently available, essential care to Medicaid beneficiaries. Medicaid now cares for over 30 million poor seniors, disabled people and families with children. These vulnerable people should not be asked to surrender essential care to help pay for national health care reform.

Unfortunately, three features of the September 7 draft plan do exactly that. First, Medicaid beneficiaries, along with other low-income people, will be asked to make substantial co-payments for basic primary care. Medicaid currently scales down co-payment amounts to fit low-income budgets and safeguards access to care. Most commonly, state Medicaid programs have chosen to impose no co-payments on the poor. Copays rarely exceed \$2 for physician and mental health visits or \$1 for prescription drugs. States may adopt total caps on copays that protect low-income people with significant health care needs. Medicaid also requires providers to serve those who cannot pay co-payments in advance, permitting only later billing in such cases. Finally, certain categories of people (e.g., children and pregnant women) and services (e.g., family planning) are exempt from co-payments under Medicaid.

Second, the Administration's plan may end many crucial Medicaid-covered services that are outside the plan's benefits package. Such services include:

- preventive checkups for children and adolescents as recommended by the American Academy of Pediatrics, which exceed the periodicity schedule in the September 7 draft plan;
- many rehabilitation and therapy services for congenitally disabled children and adults, particularly where such services prevent deterioration in function but do not cause rapid improvement;
- restorative dental care for children, such as fillings and treatment of gum disease;
- mental health services for the seriously mentally ill, beyond the limits in the draft plan (e.g., 30 outpatient therapy visits per year, and 30 days' hospitalization per spell of illness); and

*dental services and eyeglasses low-income adults need for employment.

Under the Administration's plan, Medicaid beneficiaries would lose guaranteed coverage of these services. Instead, states would receive block grants, along with the power to deny benefits as they see fit.

Third, Medicaid beneficiaries not receiving cash assistance would be forced, for the first time, to pay premiums for health insurance. Nearly 40% of Medicaid beneficiaries fall into this category.⁹ Such premium payments would force them to go without other necessities of life. According to one recent study authored by academics at Harvard and the University of Chicago and the President of the Kaiser Foundation, among current Medicaid beneficiaries:

- *28% reported not having enough money to buy food;
- *31% lacked money needed to pay their rent or mortgage; and
- *29% could not pay their heat and light bills.¹⁰

At the very least, the Administration's plan should do no harm to the vulnerable members of our community who have achieved precarious health coverage through Medicaid.

In conclusion, Mr. Chairman, combinations of sweet and sour flavors may do well in restaurant reviews, but when the Administration's plan comes before the Congress, we hope you will do your best to keep the sweet and change the sour.

⁹Congressional Research Service, Medicaid Source Book: Background Data and Analysis (A 1993 Update) (January 1993) p. 589 (38%).

¹⁰Blendon, Donelan, Hill, Scheck, Carter, Beatrice, Altman, "Medicaid Beneficiaries and Health Reform" *Health Affairs* (Spring 1993) p. 141.

Chairman STARK. Mr. Kirsch.

**STATEMENT OF RICHARD KIRSCH, EXECUTIVE DIRECTOR,
CITIZEN ACTION OF NEW YORK, CITIZEN ACTION**

Mr. KIRSCH. Good morning. I guess good afternoon now. My name is Richard Kirsch. I am executive director of Citizen Action of New York, and I am testifying today for National Citizen Action, a grassroots consumer lobby with 3 million members nationally and offices in 31 States.

It is very clear what consumers want in health care. They want to know they will be covered, which means they will be able to afford their coverage. They want their coverage to meet all their health care needs, from cradle to grave, preventive care to long-term care. They want to be able to choose their own health care provider, and they want to know they will be able to afford the care that the provider offers them.

The proposal that meets these common sense consumer needs is H.R. 1200, introduced by Congressmen McDermott and Conyers, sponsored by the chairman as well as more than 80 other Members of this House.

H.R. 1200 sets the standards by which consumers will measure all other proposals. We urge Congress to pass H.R. 1200. Should that not come to pass, Congress certainly should allow States to provide better access, better coverage, guaranteed affordability, and complete freedom of choice to their residents through the single-payer State option. The State single-payer option must be available to States without burdensome Federal waivers and without restrictions on States' ability to raise revenues for health care.

In the few minutes I have this morning, I want to focus on the first concern of consumers: Will they be able to afford their health plan? If they can't afford it, they won't get it; and the proposal, no matter what it says, will not be universal.

The point I am making is exactly that which Mr. Grandy and Ms. Porter talked about before. The Clinton plan, as do other proposals—such as that offered by Mr. Cooper, Mr. Grandy and Mr. Michel—all start with a flawed premise for affordability: Rather than base premiums on how much people can afford, premiums are based on family size and geography, factors unrelated to income. Then to try to correct this flaw, and in order to do so, the plans begin to look like a welfare system, asking working people to apply for subsidies based on their relationship to the poverty level. Who are these families? They are today's uninsured, more than 80 percent of whom are in working families but who hold down low-wage jobs, part-time jobs, seasonal jobs, or are self-employed.

I like to think about a typical family, the husband, works seasonal construction, makes a good income when he is working, but he is not always working. His wife works as a cashier on the weekends and evenings. Under the Clinton plan, they will have to pay 100 percent of the premium, less what their employers contribute, less whatever their subsidies are, if they apply for subsidies and if they end up qualifying for subsidies. But they don't know how much they will work at the beginning of the year or during the year, for that matter. They don't know what their employer's contribution will be, how much their subsidy will be, or if they will be

eligible, or if they will have the cash to pay for the premium when the husband is laid off.

In short, for this family and millions like them, the bright promise of the Clinton health security card may not be within their financial reach.

Now let me make it clear that the plans covered by Mr. Cooper, Mr. Grandy, and Mr. Michel are far worse. At least under the Clinton plan, the employers will pay 80 percent of the premium for the time the family is working. The Cooper and Michel plans don't ask employers to contribute at all. These proposals offer no promise of health security.

To go back to the debate that Mr. Grandy had before, he said his bill subsidizes up to 200 percent of the poverty level. But that is for the entire premium. That means a family that makes \$30,000—that is above 200 percent of the poverty level, a family of four—is going to have to pay that entire \$3,500 or \$4,000 premium. They won't be able to afford it.

The Clinton plan does two things—at least the proposal does; we will see what the bill does. The plan does two things: It subsidizes up to 150 percent for a working family, which Mr. Grandy talked about, but only for the 20 percent share the family has to pay. And then when you get these part-time workers who get some employee contributions and some employer contributions, then it is up to 250 percent of the poverty level. That is still not good enough.

We can fix the Clinton plan to make the health security card affordable. It is very simple. We set the family premium as a percentage of income. Have family members pay into the system when they are working. When they are not working and they don't have any other income, they shouldn't pay in. That is the best way to do it.

Now, even within the Clinton system of flat premiums, as flawed as it is, you can still salvage affordability. The plan should do for individuals what it does for business, limit the amount of premiums a family pays to a percentage of income.

After all, the Clinton plan reassures businesses who will also be paying flat premiums that, no matter what, they won't have to pay more than 7.9 percent of payroll for health care; for small, low-wage businesses, as little as 3.5 percent. And, of course, businesses only pay for employees when they are on the payroll.

What is good for American business certainly should be good for American families. Americans will be able to afford their health coverage if premiums are limited to a percentage of income, with lower limits for lower-wage families.

The Clinton plan has other essential measures that need to be maintained if the basic financial underpinnings of private insurance are to be fair and affordable. The opt-out for large businesses should be eliminated. By no means, no further reduction of the opt-out can be allowed. That fundamentally undermines financing for those in the health alliances and would be very costly to taxpayers.

Pure community rating must be maintained, and the risk adjustment system must be up and working. We actually have some experience in New York on how to do the risk adjustment system from the new community rating law.

Let me conclude by saying that if we guarantee affordability of premiums and keep these essential insurance reforms, this health security card will actually be attainable. If not, it is not going to be within everybody's grasp.

Thank you.

Chairman STARK. Thank you.

[The prepared statement follows:]

Testimony of Richard Kirsch
 Executive Director - Citizen Action of New York
 Ways and Means Health Sub-Committee
 U.S. House of Representatives
 October 21, 1993

Good morning Chairman Stark, members of the Committee. My name is Richard Kirsch, Executive Director of Citizen Action of New York. I am testifying today on behalf of national Citizen Action, a grassroots consumer lobby with 3 million members and offices in 31 states.

When consumers consider health care they have four, very simple questions that need to be answered, the same question anyone would ask if they were to purchase a private insurance policy:

1. How do I qualify for coverage?
2. Will I be able to afford the coverage?
3. Are all my health care needs covered?
4. Who can I go to and get health care?

In going through this common-sense check list, it is very clear why consumers prefer HR-1200, the American Health Security Act, introduced by Mr. McDermott and Mr. Conyers and now sponsored by more than 80 members of the House. Alone among the leading health care proposals it:

1. Covers every resident with the same standard of care, without regard to age, income, work or health status;
2. There are no financial barriers to care, either through premiums or out-of-pocket costs;
3. It provides comprehensive coverage of all health care needs, from preventive through long-term care;
4. It offers complete freedom-of-choice of health care provider, without any financial burden for exercising that choice.

HR-1200 sets the standard by which consumers will measure all other proposals. We urge Congress to pass HR-1200.

Should that not come to pass, Congress certainly should allow states to provide better access, better coverage, guaranteed affordability and complete freedom-of-choice to their residents, through the single-payer state option. The state single-payer options must be available to states without burdensome federal waivers and without restrictions on states' ability to raise revenues for health care.

The Clinton health care plan fails to realize the ideal on any of the four measures consumers will use. It's not the best policy. But it does have many good features, and even within its faulty framework can be improved to deliver good health coverage to consumers. In the following we describe how the Clinton plan measures on the four basic consumer questions and how it can be improved:

Coverage. The plan does offer a health security card to every resident. But senior citizens are kept under a separate system, a system with less coverage and higher costs. In addition, full-time employees of corporations who employ more than 5,000 may be put in a separate system, with different and probably fewer choices of health plan.

Coverage improvements in the Clinton plan:

1. Provide the same benefits to senior citizens as to those in the health alliances, and provide Medicare beneficiaries with the same limitations on out-of-pocket costs.

2. Eliminate the opt-out for large employers.

Affordability - premiums. The Clinton plan, as do other proposals such as that offered by Mr. Cooper and Mr. Michel, all start with a flawed premise for affordability. Rather than base premiums on how much people can afford, premiums are based on family size and geography, factors unrelated to income. Then, to try to correct this flaw, the plans look like a welfare system, by asking working people to apply for subsidies.

Who are these families? They are today's uninsured, 88% of whom are in working families, but who hold down low-wage jobs, part-time jobs, seasonal jobs, or are self-employed. I like to think about a typical family: the husband works seasonal construction, and makes a good income when he's working, but he's not always working. His wife works as a cashier at K-Mart, weekends and evenings. Under the Clinton plan they'll have to pay 100% of the premium, less what their employers contribute

when they work, less whatever the subsidies are, if they apply, if they qualify. But they don't know how much they'll work, what their employer contribution will be, how much their subsidy will be or if their eligible. Or, if they'll have the cash to pay their premiums when the husband is laid-off.

In short for this family, and millions like them, the bright and very welcome promise of the Clinton Health Security Card, may not be within their financial reach.

Of course, plans such as offered by Mr. Cooper and Mr. Michel are far worse. At least under the Clinton plan, employers will pay 80% of the premium for the time the family is working. The Cooper and Michel plans don't ask employer's to contribute at all; these plans offer no promise of health security to Americans.

Making Premiums Affordable Under the Clinton plan. To best way to make premiums affordable under the Clinton plan, and therefor make the plan truly universal, is to set the individual/family premium as a percentage of income, and have family members pay into the system when they are working. When they're not working, or don't have other income, they shouldn't pay in.

While this would be the best route, the simplest route, even within the flawed Clinton system of flat premiums, affordability can still be salvaged. The plan should do for individuals what it does for business:

1. Limit the amount of premiums a family pays to a percentage of income, with lower limits for lower-wage families.
2. Require premium payments only when individuals are employed and have no other income.

After all, the Clinton plan reassures businesses, who will also be paying flat premiums that, no matter what, they won't have to pay more than 7.9% of payroll for health care. And for small, low-wage businesses, as little as 3.5%. And of course, businesses only pay for employees when they are working.

What's good for American business is certainly good for American families. Americans will be able to afford their health coverage if premiums are limited as a percentage of income, with lower limits for lower-wage families.

The Clinton plan does have other essential measures that need to be maintained if the basic financial underpinnings of the private insurance system are to be fair and affordable:

1. The opt-out for large business should be eliminated. And by no means further reduce the opt-out; that would fundamentally undermine financing for those in the health alliance system and be very expensive to taxpayers;

2. Pure community rating must be maintained. Any dilution of the community rating system, for example by allowing age to be a rating factor, raises health care costs to those who most need health care;

3. The risk adjustment system must be up and working, and include poverty as well as demographic and health costs as factors.

Affordability - Out-of-Pocket Costs. The out-of-pocket costs in the Clinton plan will prevent access to health care for low and moderate income people. Ten dollars a visit may not seem like a lot for most families, but it is a great deal to a family that doesn't have the money. And a low-income family with three kids, all of whom have ear infections, will be facing a \$30 charge.

Out-of-pocket costs can also mount up quickly for the very sick or for those who have special health needs and need to be in the fee-for-service system, in order to have access to specialists who know how to care for them.

Improving the Affordability of Out-of-pocket Costs in the Clinton Plan:

1. Eliminate out-of-pocket costs for all individuals who are now eligible for Medicaid and for others with low-incomes;

2. Eliminate the out-of-pocket costs for the new Medicare prescription drug benefit for low-income seniors;

3. Subsidize the fee-for-service out-of-pocket costs for people with low-incomes and disabilities or chronic health conditions.

Benefits Under the Clinton Plan: While the Clinton's plans benefits are generally good they still are lacking in several important respects. Benefits are usually kept out of a plan not because they aren't needed, but in-order to "save" money for the plan. For instance, excluding adult dental care doesn't cure tooth decay; it lowers the cost of the benefit package. But does it save money? The person whose teeth are rotting

still has to pay the dentist. And it may cost him or her more if the lack of preventive dental coverage delayed a visit to the dentist, and the tooth decay is advance. Excluding coverages only saves money for the plan; it shifts costs to consumers and to the health care system. Instead, all measures that maintain health and cure disease should be included in the plan and benefit from the insurance concept.

Benefit Improvements Needed in the Clinton Plan:

1. Lower the threshold for long-term-care to two Activities of Daily Living and add institutional long-term-care;
2. Provide full mental health coverages immediately.
3. Medicare recipients should receive the same benefits as other Americans, including preventive care and dental care.

Freedom-of-Choice: For the many Americans whose choice of health care plan is now restricted by their employer, the Clinton plan increases freedom-of-choice. But the plan's emphasis on managed care may deny access to freedom of choice to Americans who can't afford the higher premiums and out-of-pocket costs in the fee-for-service system. The higher costs of fee-for-service will be a serious burden to people with serious or chronic medical problems, and who need access to certain providers or to a range of specialists that may not be found in any one plan. In addition, allowing managed care plans to compete on price, rather than quality, will permit them to provide inferior health care and still attract people who can't afford higher cost plans.

Improving Freedom-of-Choice in the Clinton Plan:

1. Require states to limit any plan premiums, including fee-for-service, to no more than 20% greater than the weighted average premium;
2. Subsidize the fee-for-service premium for low-and-moderate-income people with serious or chronic health problems, or with disabilities.

Cost Controls: The sophisticated American consumer will ask one more question: will I be able to afford my coverage next year? The scourge of double-digit health care price increases must be stopped. The Clinton plan's provisions requiring caps on insurance premiums, as a backstop to

managed competition, are an essential part of the plan. The price caps must be maintained if the nation is to have any assurance that health care costs will be affordable to families, businesses and taxpayers.

Improving Cost Controls in the Clinton Plan:

1. Directly limit price increases for prescription drugs, medical equipment and supplies. These national products are not as amenable to local negotiations and networks as provider fees;
2. Limit insurance company administrative costs to 5% of premiums. After all, that is a figure almost 2.5 times the administrative cost of Medicare. Assuring that 95% of premiums go to pay for health care, rather than administration and profit, will not only control costs, but will limit skimping on care and improve quality;
3. Prohibit case-by-case utilization review. As the Congressional Budget Office has found such review is more costly than reviewing physician practice patterns. Limiting such review will mean that a patient and provider will make decisions on health care, not an insurance company. But it will still allow managed care plans to review and improve physician practice.

Before concluding, we should note that plans such as proposed by Congressman Michel (HR-3080) and Congressman Cooper (HR-3222) fail to meet any of the four consumer measures. The plans create many tiers of health care coverage, are unaffordable in both their premiums and out-of-pocket costs to millions of Americans, don't promise any level of benefits, deny freedom-of-choice of provider and allow health care costs to continue their upward death spiral.

The improvements we propose for the Clinton plan will still not make it as simple, as affordable or as accountable to consumers as the single-payer plans. Congress should instead enact HR-1200. If single-payer is not enacted on the national level, Congress should make the state single-payer option easy to implement.

While the changes we propose in the Clinton plan won't make it as consumer-friendly as HR-1200, they will vastly improve on the President's proposal. By changing the President's proposal as we have suggested, Congress will deliver on President Clinton's promise of health security for all Americans.

Thank you.

Chairman STARK. Ms. Cain, you were scheduled to be third, and you sat in the wrong seat; and it just confused the Chair. So I apologize. But we saved the best for last.

Why don't you, representing the League of Women Voters, begin.

STATEMENT OF BECKY CAIN, PRESIDENT, LEAGUE OF WOMEN VOTERS OF THE UNITED STATES

Ms. CAIN. Thank you. And I apologize for having been in the wrong chair.

Mr. Chairman, members of the subcommittee, I am Becky Cain, president of the League of Women Voters of the United States. I am very happy to be here today to comment on President Clinton's proposed health care reform plan.

The League of Women Voters is a nonpartisan citizen organization with approximately 200,000 members and supporters nationwide.

The health care system has concerned League members for many years. In 1990, we began a 3-year intensive study on the delivery and financing of health care in the United States. Leagues and League members across the country carefully examined the problems and considered solutions to the health care crisis.

After thousands of hours of grassroots debate, League members reached consensus on health care reform. That consensus is the basis for my testimony today.

The League of Women Voters believes that fundamental health care reform must provide universal access to quality health care for all U.S. residents, regardless of ability to pay, and must include stringent cost control measures for health care outlays.

It is clear that our current health care system is failing. It is failing our Nation's families, and it is failing our Nation's economy. Something is fundamentally wrong when mothers cannot afford prenatal care, when children don't receive routine vaccinations, when working families cannot afford health insurance, and when older parents are left destitute, without adequate long-term care.

In a recent national public opinion poll, Americans ranked health care as the most important issue for citizens to get involved in, more important even than the economy and the environment.

Health care is on the mind of every citizen in America today. And the League of Women Voters wants to ensure that the concerns of citizens are on the mind of every legislator involved in shaping tomorrow's health care system.

As citizens, we say to you, our elected representatives, as clearly and as forcefully as we can, fix these problems; pass comprehensive health care reform.

The League of Women Voters believes that President Clinton's health care reform package does mark a critical step forward. It will fix the fundamental flaws in our Nation's health care system, and it does offer real reform.

Under the plan, Americans will be covered no matter where they live, where they work, or how much they earn. The plan's basic benefits package will be a boon to people's health. For the first time, all Americans will be guaranteed coverage for preventive, primary, and acute care; and reproductive health services including

abortion are in the plan. Mental health services and long-term care are also included but are limited to keep costs down.

Among the plan's most critical features are its built-in cost control measures. By standardizing forms, introducing new competitive structures, and limiting spending, the plan has effective ways of cutting waste and reducing costs.

The President's health care plan is not perfect, but it is fair. It will need some fine tuning in the legislative process. For example, citizen and consumer participation must be included in all aspects of the plan's implementation to ensure that government-sponsored programs are responsive to people's needs.

The administration of the health care system must be a process in which citizens can express their views and participate. We believe that State and Federal programs, and especially the health alliances that will be created as a result of health care reform, should follow the Federal policy of open government, including open meetings, full access to information, open regulatory processes, adequate comment periods, and other protections to make sure that citizens are involved and aware.

Health care reform will need bipartisan support. The League is encouraged that many of the goals for reform are now shared by key Members of both political parties on Capitol Hill. Congress must not lose sight of the cost of inaction on this critical issue. Americans cannot afford a protracted political debate on national health care reform.

There will be no perfect solution to this crisis. Not everyone will get everything they want. But for once, everyone has the possibility of getting what they need. This, in itself, will be a giant step forward. We need a viable plan that gives all Americans a more humane health care system.

The President's plan is an effective blueprint for reform. Congress must now seize the momentum. There can be no turning back. It is time to forge ahead and enact comprehensive health care reform.

Thank you, Mr. Chairman.

[The prepared statement follows:]



THE LEAGUE
OF WOMEN VOTERS

FOUNDED 1911

TESTIMONY BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE HOUSE WAYS AND MEANS COMMITTEE
ON
PRESIDENT CLINTON'S HEALTH CARE REFORM PLAN
BY BECKY CAIN, PRESIDENT
THE LEAGUE OF WOMEN VOTERS OF THE UNITED STATES

October 21, 1993

President
Becky Cain
St. Albans, West Virginia

Vice-Presidents
Diane B. Sheridan
Taylor Lake Village, Texas

Peggy Lucas
Minneapolis, Minnesota

Secretary-Treasurer
Robin Seaborn
St. Petersburg, Florida

Directors
Pat Brady
Springfield, Virginia

Marlyn F. Brill
Danville, Pennsylvania

Jane S. Garbacz
Wilton, Connecticut

Bobbee E. Hill
Camden, Arkansas

Debbie Macon
West Bloomfield, Michigan

Beverly K. McKinnell
St. Paul, Minnesota

Linda Moscarella
Taos, New Mexico

Nancy Pearson
Tacoma, Washington

Carole Wagner Vallentyne
Manhattan Beach,
California

Kathleen Wewenberg
Atherton, California

Executive Director
Gracia M. Hillman

Mr. Chairman, members of the subcommittee, I am Becky Cain, president of the League of Women Voters of the United States. I am very happy to be here today to comment on President Clinton's proposed health care reform plan. I would also like to discuss the critical need for comprehensive health care reform and to outline the League's views on what should be included in any effective reform plan.

The League of Women Voters is a non-partisan citizen organization with approximately 200,000 members and supporters in all fifty states, the District of Columbia, Puerto Rico and the Virgin Islands. For almost 75 years, Leagues across the country have worked to encourage the informed and active participation of citizens in government. The League is expert at giving citizens the tools necessary to make important decisions on critical public policy issues.

The health care system has concerned League members for many years. In 1990, we began a three-year intensive study on the delivery and financing of health care in the United States. Leagues and League members across the country carefully examined the problems and considered solutions to the health care crisis. After thousands of hours of grassroots debate, League members reached consensus on health care reform. That consensus is the basis for my testimony today.

The League of Women Voters believes that fundamental health care reform must provide universal access to quality health care for all U.S. residents regardless of ability to pay and must include stringent cost control measures for health care outlays.

It is clear that our current health care system is failing. It is failing our nation's families and it is failing our nation's economy. Millions of Americans are losing the battle to keep up with rising health care costs. As a nation, we spend \$1 out of every \$7 we earn on health care. Families feel uncertain about their ability to afford adequate care. An extended hospital stay or long-term care for aging parents can deplete any family's budget. Our nation's businesses cannot compete in a world economy, and we cannot assure good-paying jobs, when health care costs are spiralling out of control.

For those who cannot afford health insurance -- and 37 million people have no health insurance -- the picture is even more grim: no doctor when one is needed, no medicine when illness strikes. Something is fundamentally wrong when mothers can't afford prenatal care, when children don't receive routine vaccinations,

when working families can't afford health insurance, and when older parents are left destitute without adequate long-term care.

In a recent national public opinion poll, Americans ranked health care as the most important issue for citizens to get involved in -- more important even than the economy and the environment. Health care is on the mind of every citizen in America today. And the League of Women Voters wants to ensure that the concerns of citizens are on the mind of every legislator involved in shaping tomorrow's health care system.

As citizens, we say to you, our elected representatives, as clearly and as forcefully as we can: Fix these problems; pass comprehensive health care reform.

The League of Women Voters believes that President Clinton's health care reform package marks a critical step forward. It will fix fundamental flaws in our nation's health care system. It is real reform.

Under the plan, Americans will be covered no matter where they live, where they work or how much they earn. The plan's basic benefits package will be a boon to people's health. For the first time, all Americans will be guaranteed coverage for preventive, primary and acute care; and reproductive health services, including abortion, are in the plan. Mental health services and long-term care are also included, but are limited to keep costs down.

Among the plan's most critical features are its built-in cost control mechanisms. By standardizing forms, introducing new competitive structures and limiting spending, the plan has effective ways of cutting waste and reducing costs.

The President's health care plan is not perfect but it is fair. It will need some fine-tuning in the legislative process. For example, citizen and consumer participation must be included in all aspects of the plan's implementation to ensure that government-sponsored programs are responsive to people's needs.

The administration of the health care system must be a process in which citizens can express their views and participate. We believe that state and federal programs, and especially the health alliances, that will be created as the result of health care reform should follow the federal policy of open government, including open meetings, full access to information, open regulatory processes, adequate comment periods, and other protections to make sure that citizens are involved and aware.

The health system must also be responsive to the needs and perspectives of people as consumers. We believe that health alliances should, as stated in the President's plan, disseminate information to consumers regarding quality and access; prepare comparative reports on the quality of health plans, providers and practitioners; and conduct education programs to assist consumers in choosing health plans. We support the provisions for including consumer representatives at many levels of the President's plan.

In short, we believe the President's plan is an effective blueprint for health care reform and we urge its speedy consideration.

I would like to take a few minutes to outline the League's views on several key points that we believe should be included in any health care reform plan.

First, a reform plan must achieve universal coverage for all U.S. residents. Reform must establish a basic level of quality health care regardless of ability to pay.

Universal access is the basic test of the humanity of our health care system. The most advanced nation on earth must be able to assure adequate health care for all.

Universal access is also important as a cost control measure. Under the present system, cost shifting occurs when uncompensated care for the uninsured is passed along to the rest of us in the form of higher prices. In addition, illnesses left untreated because people don't have insurance are much more expensive to cure when someone finally goes to the emergency room.

How can universal coverage be achieved? The League favors a national health insurance plan financed through general taxes -- a so-called "single-payer" plan. We also believe that an "employer-mandate" system is acceptable.

Under an employer-mandate system, employers would be required to pay most of the costs of purchasing health care coverage for their employees and their families, who would pay the balance. The government would pay for those who are not in the work force, while small businesses would receive subsidies to assist them in providing coverage.

Because it builds on the existing system, under which most people get health insurance coverage through their family's employment, an employer-mandate system can achieve universal access without large disruption of the health care delivery system. In addition, because health care is a traditional form of compensation, and because it assures a healthy and productive workforce, it is appropriate for employers to continue to pay for health care.

Some have proposed that universal access be accomplished by requiring individuals to purchase health insurance. Often these proposals also provide tax incentives to encourage participation. Because such a system is very difficult to enforce, and because the type of coverage in such proposals is usually very spartan, this method can fall short of providing universal access to quality care. The League does not support such proposals.

Another important access issue is the problem of underserved areas. Too often, quality health services are not available in rural areas or inner cities. It is critical that the United States allocate resources to underserved areas and train health care professionals in needed fields.

The second crucial issue for any health care reform plan is the type of coverage that is included. The coverage must be broad and inclusive enough to protect people's health. But coverage must be limited to ensure that costs are not excessive. Striking the proper balance is one of the most difficult issues in the health reform debate.

The League of Women Voters believes that a basic package of quality services should include the prevention of disease, health promotion and education, primary care (including prenatal and reproductive health services), acute care, long-term care and mental health care. Dental, vision and hearing care are also important but lower in priority.

Primary care, the general "wellness" care received by a patient, is critical. Currently, the lack of primary and preventive care often results in serious illness and expensive medical intervention. By providing care such as prenatal care to all pregnant women and routine vaccinations to all children, we can save lives and money.

Acute care, the treatment of illnesses or injuries, is also critical. Providing this care to all U.S. residents would reduce cost shifting and help control costs, in addition to ensuring better health for all.

As Americans live longer, the need for long-term care is a reality for almost every family. Long-term care for persons who are chronically ill or mentally or physically disabled is also essential. Our current infrastructure for long-term care, however, is lacking. We need to look for new ways to deal with these problems, such as care in the home, that are not exceedingly expensive. In any case, a start must be made on long-term care.

A start must also be made on mental health care. It is abundantly clear that mental health care pays real dividends in lives saved, in pain relieved, in families assisted and in workers helped to remain productive.

I would like to say a few words about abortion services. We believe that abortion services must be included in the standard benefits package, just like any other safe, effective and legal medical procedure. A woman and her doctor must make the difficult decisions about reproductive health care -- Congress has no business making those decisions. Generations of women and men have fought to ensure access to safe abortion services. Such services are now included in many women's existing health plans. Make no mistake, removing abortion services from the benefits package would take away something fundamental from women across the country.

The third key issue in health care reform is cost control. A simple look at the numbers illustrates the problem. Between 1980 and 1991, the total amount spent on health care per family more than doubled. Without strong action, it will more than double again by the year 2000. America's families can't afford this and neither can America's businesses.

The League believes it is absolutely essential to achieve a reasonable total national expenditure level for health care. In order to control costs, legislation to reform the health care system should include specific cost-cutting measures such as:

- o the reduction of administrative costs;
- o regional planning for the allocation of personnel, facilities and equipment;
- o the establishment of maximum levels of reimbursement to providers;
- o malpractice reform;
- o the use of managed care;
- o utilization review of treatment;
- o mandatory second opinions before surgery or extensive treatment;
- and
- o consumer accountability through deductibles and copayments.

Such techniques hold real promise for controlling costs. According to some estimates, at least \$130 billion a year is spent on unnecessary care. Managed care, which is designed to limit inappropriate or excessive utilization of health care services, can provide more efficient and economical delivery of care. Increased consumer accountability through deductibles and copayments can also help cut overutilization.

With 24 cents of every health care dollar going to administrative costs, it is apparent that administrative procedures must be streamlined, resulting in substantial savings. In Canada, which uses a single-payer system, the cost is 11 cents of every dollar. It is also vitally important to reduce duplication of services, facilities and equipment, such as costly, high-tech diagnostic machines.

In addition to specific cost control techniques, however, health care reform must include an overall mechanism to ensure that savings add up. There must be a back-up mechanism to oversee and coordinate cost-cutting efforts. We think that global budgeting can provide that needed mechanism. National and regional boards comprised of policy makers, medical professionals, and consumers could set goals or limits for spending at the national, state and local levels. Governments and health providers would then operate within those limits. Careful consideration needs to be given to how global budgeting will operate. We need to make sure that cost controls are consistent with quality and are not arbitrarily imposed. But the need for such global budgeting is

clear. We believe it should be included in health care reform legislation.

The fourth and final key issue in health care reform is how to pay for it. Substantial savings can be achieved over the current health care system, and these savings should be applied to ensuring that all U.S. residents have a basic level of quality health care. No doubt a large part of the debate over the next several months will be over the size of those savings. Whatever the outcome, however, we believe that the goal of universal access is worth paying for. That is why we support increased taxes to finance a basic level of health care for all, provided effective cost control strategies are employed.

The League looks at a variety of factors when evaluating the acceptability of taxes, but we are particularly concerned that the overall health care reform package is fair, equitable and progressive. The League would support a general income tax increase to finance national health care reform and could support restrictions on the deductibility of health care benefits. We strongly oppose a value added tax (VAT) or national sales tax. This is a highly regressive tax and would unfairly burden low and middle-income Americans.

The League does support increases in so-called "sin taxes" on such products as cigarettes and alcohol as part of a reform package that encourages Americans to lead healthy lifestyles. Such taxes discourage the excessive use of these harmful products and will actually serve as "preventive medicine."

In summary, the League of Women Voters calls on Congress to enact national health care reform that provides for universal access to quality health care and for stringent cost control measures.

Health care reform will need bipartisan support. The League is encouraged that many of the goals for reform are now shared by key members of both political parties on Capitol Hill. Congress must not lose sight of the costs of inaction on this critical issue. Americans cannot afford a protracted political battle on national health care reform. There will be no perfect solution to this crisis. Not everyone will get everything they want. But, for once, everyone has the possibility of getting what they need. This, in itself, will be a giant step forward.

We need a viable plan that gives all Americans a more humane health care system. The President's plan is an effective blueprint for reform.

Congress must now seize the momentum. There can be no turning back. It is time to forge ahead and enact comprehensive health care reform.

Chairman STARK. Thank you.

It is no secret, as much as I would protest my impartiality, that given a free choice to be king for a day, I would prefer a single-payer approach that resembles Medicare for all. But there are others who believe that we should retain more of the current system and, indeed, allow health plans to compete one with the other.

And I assume that, to get a bill that will have universal coverage, we are going to have to compromise to get the votes.

So if a so-called competitive model will prevail, would the witnesses support an effort to allow Medicare in its present form to compete with the other health plans, allowing individuals, businesses, groups, the option to buy into a Medicare-type system, the theory being that under Medicare today individuals can choose any physicians?

They would have the benefit of Medicare's cost containment and savings from overhead, or they could choose to enroll in private plans like Kaiser, Prudential, Blue Cross, or anybody else.

Would you like to start off, Gail, and just go down the line and tell me how you would feel about that.

Ms. SHEARER. While our organization doesn't have an official position, my initial reaction is very positive for several reasons.

The Medicare program has been very successful in achieving extremely low administrative costs, on the order of 2 percent of its total budget.

The other key advantage that this type of option has, is that a public program, a Medicare-type of program, is accountable to the public. Whereas the health plans outlined in the Clinton bill are accountable to their shareholders.

And so the fact that this part of the program would be accountable to consumers, to the public, is very appealing.

Chairman STARK. Thank you.

Mr. DORN. So much depends on the details, it is difficult to give you an answer. And, obviously, it would be good to have a chance to think. But I think that has an enormous amount of potential.

Chairman STARK. Mr. Kirsch.

Mr. KIRSCH. Since we are going to be saying that every health alliance has to have a fee-for-service plan, instead of creating new ones, why not just do Medicare and at least be sure you integrate the fee-for-service.

Chairman STARK. I hadn't intended it to be that restrictive. I just want to make sure that it is there.

Mr. KIRSCH. That way you would have a fee-for-service system with a lot of providers, a lot of people, you don't have to worry about getting a restrictive fee-for-service system.

And then you also want to be sure that Medicare would have benefit-risk adjustments and would have out-of-pocket limits. But Medicare can compete with the alliance systems. Let's not disadvantage it.

Chairman STARK. It would presume that the minimum benefit, whatever that is going to be—

Mr. KIRSCH. The same as other plans. More than Medicare—

Chairman STARK. I didn't want to talk to the last panel about the new notch that we would create if we had a different benefit for Medicare. But this Congressman is not going to create a whole

new generation of notchers. I mean that—my life is complicated enough, thank you.

Ms. Cain.

Ms. CAIN. Well, we certainly would be willing to look at the option. Our concern is that we get everybody covered and that we keep costs low. So, those would be our concerns.

Chairman STARK. OK.

Ms. Shearer, the plan proposes to regulate any private supplemental market much as we did for Medicare supplements. I know that you and your organization have been in the forefront of reviewing insurance programs and its regulation and so forth.

One thing that is interestingly absent in the President's plan is that there was no regulation of so-called dread disease or crap shoot policies of indemnity style.

I think you believe they should be banned. But short of that, what minimum Federal standards would you recommend for those policies? And why do you think they must be regulated?

Ms. SHEARER. Chairman Stark, we believe there is no role for either hospital indemnity policies or dread disease policies in a reformed health care system.

We have trouble with them in the system that we have today. These tend to be very, very low-value policies. They would represent a total wasted—unnecessary expense in a reformed system where we are trying to get the rein in on costs.

With regard to the supplemental market—and this is an area where this committee has done so much to reform the medigap market in particular—the draft plan has some provisions for setting up standard policies for cost sharing supplemental policies.

We believe that the plan should go further and that the supplemental policies that cover benefits not in the standard benefit package—that there should be standard packages available for that part of the market as well, and we hope that this subcommittee would take the lead on that type of a modification.

Chairman STARK. Recognizing that often in the case of motorcycle helmets or even, indeed, State lotteries, that it is beyond legislators to protect the public from themselves, and that there are some things that the public is just going to do—smoke, gamble, whatever they choose—would you have any objection to our integrating those types of policies into State lotteries, to have slightly worse odds than State lotteries to help you, but as long as people are going to do them, we would let the States benefit from the egregious profits that are made and they could, then, use the benefits for other charitable things?

Would you say that that might be a good way to deal with the public's propensity to gamble in this area?

Ms. SHEARER. Well, I think that it would help to educate consumers, that what they are entering is a lottery-type of arrangement when they buy one of these policies. It would certainly help from a consumer education point of view. Whether the regulatory framework really works, I am not prepared to comment on that.

But another option to consider would be applying a 90 percent loss ratio to these policies, which would have a major impact on their ability to sell them.

Chairman STARK. Someday we have to do what we did in our sixth grade or eighth grade math class. When we learned about statistics, we had a slot machine which had recently been outlawed in Wisconsin. And they had a rule in Wisconsin, God bless them, that the slot machine had to pay back 95 percent. And it did.

But you really, then, found out what a profitable sort of thing those slot machines are. So I guess what you are suggesting, if we let these guys have 90 percent, they ought to make at least as much money as the slot machines in Las Vegas.

Ms. SHEARER. Let me repeat: It is our clear preference that Americans not waste billions of dollars on something they don't need.

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Mr. Chairman, the gentleman from Iowa has asked me to ask unanimous consent that we place in the record a cover letter to the letter he discussed earlier which had no letterhead but essentially trashed the Cooper-Grandy plan.

What he wants entered into the record by unanimous consent is, in fact, the cover letter indicating who it was that tried to make themselves appear to be a broad-based group.

And he asks unanimous consent.

Chairman STARK. I, without objection, make it part of the record. Although, I have a hunch that Citizens Action probably had as much to do with that letter as anybody else.

Mr. Kirsch, would you—

Mr. KIRSCH. My national staff says we did start the ball rolling on it.

Chairman STARK. I think we would have many groups step forward and claim part of the parentage of that letter.

So with that admonition, by all means, make it part of the record.

[The information follows:]

HEALTH CARE: DEFEATING THE COMING CLINTON-COOPER COMPROMISE

"You should realize our bills are very similar. The White House bill and my bill have a lot in common, and we're very proud of that.... I want the White House to win." Rep. Jim Cooper (February 4, 1994)

"In some ways I think that Jim Cooper is being extremely helpful to the process, extremely helpful to the process." Sen. Jay Rockefeller (February 4, 1994)

"In broad outline the Clinton and Cooper proposals are more alike than either side at times finds it convenient to acknowledge." *The Washington Post* (February 7, 1994)

Jim Cooper, Jay Rockefeller, and the *Washington Post* know something that many people in Washington (including, we fear, many Republicans) do not: that while the Clinton Administration's health care legislation may be in trouble, its project of reform by sweeping government dictat is, unfortunately, still alive.

The new conventional Washington wisdom about health care has it that the Clinton plan is in trouble, its current momentum stalled and its future prospects threatened by the emergence of Representative Jim Cooper's "moderate alternative." This week's *Time* goes so far as to suggest that Clinton's plan might be "DOA." Evidence for this theory is deceptively obvious. The president has been on the defensive since before his State of the Union message, which included a veto threat he apparently deemed necessary to protect legislation he had introduced just two months earlier. That speech failed to move poll numbers as intended; public support for the plan remains below levels recorded early last fall. And there have been signs of White House fear and weakness ever since.

Concerned about potential political support for less radical reform than his, the President has offered surprising (if ultimately unsuccessful) concessions in a bid for support by the National Governors Association. His aides have responded somewhat hysterically to a series of critical television ads – and to an article in *The New Republic* that convincingly detailed their plan's likely ill effect on American medical services. Tuesday's Congressional Budget Office pronouncement raises further serious questions about the plan's financing and budget effect. And last week saw a new rush of business objections to the Administration's health care proposal: tough Congressional testimony by the Chamber of Commerce, a declaration of opposition by the National Association of Manufacturers, and an outright endorsement of Cooper by the Business Roundtable.

THE CLINTON-COOPER PHONY WAR. It's true that the Clinton health care legislation, as written, is made weaker by the fresh strength of the Cooper bill. And the harsh reaction to this development by the White House and its allies seems at first glance to support the notion that large ideas are at issue in a Clinton/Cooper tug of war. But large ideas are not in fact at issue; Clinton and Cooper are instead, as the Congressman correctly claims, "first cousins in this debate and ... hoping for a family reunion this year." Both Democratic proposals involve a radical federal regulatory rearrangement of the financing and delivery of American medical services. In this respect they constitute not two political positions on health care, but only one. Clinton's health plan is by no means "dead on arrival."

The fact that Clinton and Cooper now thoroughly dominate the Washington health care debate, and thus threaten permanently to circumscribe its acceptable parameters, should alarm Republicans. Neither bill is compatible with conservative principle, and Republicans therefore have no business cheering for either side of the Clinton/Cooper controversy – much less "participating constructively" in its resolution, despite the disingenuous advice we now receive from editorialists. Any conceivable

Clinton-Cooper compromise legislation would represent an unprecedented government encroachment on the authority of individual citizens to make basic decisions about their daily lives, in this case about their very health. Republicans ought not be reluctant to defend such individual rights and oppose a Clinton-Cooper compromise that threatens them.

The health care debate is at a watershed. The Cooper bill is currently ascendant not because "managed competition" has any broad-based, intrinsic appeal, but rather, we suspect, because its Congressional and business supporters see no other politically realistic vehicle with which to register their opposition to Clinton. Republicans must now make clear that Cooper is not a meaningful departure from the Clinton vision, and must make a principled case for the real alternative solution to America's health care problems: sensible, straightforward reforms that would make insurance more stable and affordable. Those reforms have enjoyed bipartisan support in the past; they can earn such support again this year.

Unless we are prepared to oppose Clinton-Cooper vigorously and propose our own reforms intelligently, the ultimate success of Clintonism, broadly understood, will be virtually certain. The White House can meet Jim Cooper well more than half way in the public and private compromise negotiations now underway, and the president will still be able to sign the terrible result into law.

UNDERSTANDING THE COOPER BILL. Managed competition, the core of the Cooper bill, shares with the president's proposal the vision of a government-directed remaking of American health care delivery and financing. Though it comes in free-market guise, the Cooper bill would undo the medical system we now take for granted -- just as radically and completely as would the Clinton plan.

True, Cooper avoids a mandate that employers pay for their employees' health care. That has been its central attraction for business groups. But a closer examination of the bill reveals other ways in which employers would be drawn into a web of state-administered health care machinery. Firms with fewer than 100 employees (about 93 percent of all businesses), for example, would be required to register with regional Health Plan Purchasing Cooperatives, forward information about all their full- and part-time employees, and deduct from paychecks the cost of health care premiums, whether or not the firms were providing health care coverage.

Each of these purchasing cooperatives would be required to make available "accountable health plans" that offer a standard set of benefits determined by a vote of Congress. Proponents of the Cooper bill point out, correctly, that under their plan consumers might still choose plans whose benefits exceed the government's established standards. But the Cooper bill is essentially designed to limit individual choice by pushing consumers into the lowest-priced health plan in their region. Through the introduction of a tax deduction cap, both individuals and employers would be permitted to deduct only the cost of the lowest priced plan in their region. Anything beyond that would be subject to the top corporate rate. Businesses that today offer their employees generous health plans would effectively be forced either to accept the government's more austere benefit limits or face stiff economic penalties.

This is a remarkably coercive use of the tax code. The federal government would first decide what type of health insurance should be in a employee's benefit package, and then, in effect, penalize all those who choose what the Cooper bill deems "excess" health coverage. Cost savings would presumably emerge from the competition among these minimum benefit plans to become the lowest bidder in any given region. The Cooper bill advances these measures in the name of cost containment. But they are tantamount to an arbitrary government restriction on how much money goes into the health system. To retain the tax deductible status of the health plan under which they work, doctors, nurses, and hospital administrators would be driven primarily by budget priorities. The ability of patients to obtain high quality service and a full range of treatment options would invariably be compromised.

In most regions, the only plans able to meet government-set standards for certification as "accountable health plans" would be health maintenance organizations (HMOs). Representative Cooper's candor on this point has been widely overlooked. "My guess," he has said, "is that fee-for-service medicine will be discouraged and mostly die out." Alain Enthoven, one of the authors of the managed competition model, has made the same prediction: "We doubt that [private-practice doctors] would generally be compatible with economic efficiency." Seeing a specialist when you like, seeking a second opinion, choosing your own family physician -- all these things would be as rare under Cooper as under Clinton.

Surviving health plans would be further hampered by the Cooper requirement that no plan charge enrollees different rates for any reason other than age. While ostensibly designed to guarantee access to health insurance, this Cooper version of "community rating" would effectively prevent a plan from offering different premiums based on health status or medical history. Under Cooper's system, in other words, the individual who quits smoking or takes preventive health measures would be treated the same, for insurance purposes, as a smoker or someone with a debilitating disease. And both would likely wind up in the same "lowest price" accountable health plan.

For the health consumer in America, life under the Cooper plan would look very much as it would under the president's: standardized medicine, impersonal systems of care, and hospitals and doctors judged by economic efficiency standards. "Cost containment" would become the mantra of American medicine, and all incentives in the system would be geared toward cutting corners and trimming service. Doctors operating in an accountable health plan would be required to report on procedures, treatments, outcomes, patient background, expenses and other "necessary" medical information; health plans would withhold payment to any doctor who does not provide such requested data. The number of specialists trained each year would be decided and allotted by a panel of government experts.

Above everything, the Cooper system shares the president's fixation with a complex architecture of national health care bureaucracy that regulates, monitors, and coordinates virtually every aspect of the doctor-patient relationship. Like the president, Cooper would establish Health Cooperative Boards in each region. He would also create a Health Plan Standards Board to establish standards for every health plan; an Agency for Clinical Evaluations to oversee federal medical research; and a Benefits, Evaluation, and Data Standards Board to manage a national health data system. The entire structure would be governed by a Health Care Standards Commission of five presidential appointees -- an independent agency that would function as a Supreme Court of Health. While steps may be taken to shield them, all these organizations would be subject to immense pressure from politicians, interests groups, and professional health industry lobbyists. Vital decisions about experimental drugs or even routine medical procedures would become political questions. The quality of treatment patients receive, the options available to them, and the advancement of medical practice would all become tertiary concerns.

THE REPUBLICAN RESPONSIBILITY. The Clinton health care plan and its Cooper "cousin" are together a gigantic leftward social policy gamble by the Democrats, one that should be impossible to win given everything the United States has learned over the past 25 years about the failures of big-government liberalism. The White House had no right to expect anything but fierce opposition to the proposal -- from American business, which has a legitimate and necessary interest in protecting itself from government, and from Republicans, who have a comparable but even more important interest in defending both private American relationships (like that between patient and doctor) and those non-governmental institutions that remain basically sound and successful (our health care system most definitely among them). But such an opposition has not emerged, not so far at least. And if it doesn't, soon, the Clinton gamble may well pay off -- despite the fact that it pursues a misguided answer to a misconceived problem, and does so from premises a justly skeptical America has long since rejected.

For its part, the Republican Party in Congress has limited options. It can remain fractured, with various Members attached to various proposals, and hope for the best. But the best won't happen; Clinton-Cooper will pass, and the Republican Party will have been passively complicit in its passage. The Party might instead decide to play the inside legislative game of Clinton-Cooper-Chafee, working the subcommittee hearings and the committee markups, and trying somehow to influence the final bill on the margins. Clinton-Cooper passes that way, too, and Republicans will be actively implicated.

There are those Republicans prepared to argue that such a result involves no compromise of conviction. David Durenberger, for example, Cooper's only Republican cosponsor in the Senate and a cosponsor also of the very similar Chafee bill, says that "Republicans already have a winning strategy and that strategy is managed competition," which he calls a "comprehensive vision" consistent with "Republican principles." Senator Durenberger is wrong. Managed competition is not a Republican principle. It is massive social regulation, precisely the kind of thing the Republican Party should exist to oppose, and for Republicans to acquiesce or participate in its enactment would bring us no credit, and much shame.

The only honorable and realistically successful path for Republicans, then, is that outlined by Senator Dole in his calm and intelligent State of the Union response, and restated last Wednesday in a speech by RNC chairman Haley Barbour: advancing specific solutions to the problems of health care coverage, affordability, and cost that most Americans agree exist while at the same time defending our medical system's unparalleled benefits -- and making clear that those benefits are under attack by the White House. Republicans should not be deterred from this position, as some appear to have been in recent days, by press criticism and isolated polling statistics. The criticism comes from advocates of the Clinton-Cooper position. And public opinion, which political parties are formed to help shape and change, is already overwhelmingly hostile to any health care reform that would, as Clinton-Cooper will, limit the availability of medical services. Senator Dole and Chairman Barbour are making a correct argument in principle. And a winnable one.

A STARK CHOICE. There is already widespread public nervousness over the Clinton-Cooper program. New York Representative Charles Schumer, for example, reflecting on his trip home during the last Hill recess, expressed this fear quite starkly to *The New York Times*: "How are we going to explain to a majority of my constituents, who have worked hard and invested in a [health] plan that they're not terribly unhappy with, that they should jump into the abyss of the unknown?" He was talking about the Administration's legislation, of course, but the same question can and should be asked of Cooper. And when it is, Cooper's supporters -- many of whom have joined his bill for purely tactical, anti-Clinton purposes -- will be eager for an alternative to the coming Clinton-Cooper compromise.

It is the Republican Party's duty to speak for Charles Schumer's Brooklyn constituents and the silent majority of Americans who want reform but whose medical care would be badly damaged by the radical experimentation of the Clinton-Cooper health care proposals. Republicans must reframe the health care debate and offer these Americans a clear choice: a crisis-driven Clinton-Cooper "jump into the abyss," on the one hand, or real solutions to existing problems that give individual citizens, not government, more control over their health care. What is needed is not yet another "Republican plan"; instead, the Republican Hill leadership should put forward a proposal that can be the basis of effective bipartisan legislation.

The political damage recently sustained by the Clinton health care plan suggests that a Clinton-Cooper compromise will be forced on the White House sooner rather than later. It would be useful to get the principled alternative -- a proposal that might eventually become the "Moynihan-Dole" bill, for example -- on the table just as fast. This is a sound strategy for Republicans, and for the country.

Mr. THOMAS. Mr. Chairman, I am an instructed delegate.

Chairman STARK. You are recognized, then, for your own creative inquiry.

Mr. THOMAS. Thank you.

Ms. Shearer, you demand a number of things in terms of your proposal. One of the things the President has done from the very beginning is demand that if anybody wants to play the game, they have got to be as accurate as possible on the costs.

If, in fact, the Clinton plan does the things that you do and the deadlines that you seem to require them to be done, do you know how much your plan would cost?

Ms. SHEARER. Well, the—I don't really understand exactly what your question is, whether—with Consumers Union's modifications—is that what you are asking?

Mr. THOMAS. We can begin with your testimony and go page by page. You outline what you are doing in terms of requiring certain things be done in a certain way. For example, you ask for universal coverage by 1997, the President initially indicated that he wanted it by 1996. I don't know why you picked that date. Some people have some speculation as to why it was 1996. But he got beaten back, and a number of other folks in the Cabinet, for example, Secretary of Treasury, Director of Office of Management and Budget, talked about how time was money and if you do it immediately, it costs a lot. If you do it over a period of time, it costs less.

You pick a particular date and insist it occur by then. You indicate exactly what needs to be done in terms of the regulation of the prescription drug prices, on and on and on in terms of specifying very particular things that need to be done.

Do you have any indication of what, if in fact your program was the one that was implemented, it would cost, more or less, than the President's estimates?

Ms. SHEARER. There are some estimates from the Congressional Budget Office for last year's single-payer bill, which estimated that by the year 2000, total health care spending would decrease by \$150 billion.

And that is—that is the best estimate that we have of the impact on total health care costs, that the ideal system would have.

Now, my testimony today did not outline specifics, for example, of the long-term care benefit. I can't give you a Consumers Union proposal. But we strongly support H.R. 1200, and the order of magnitude that we are talking about is \$150 billion reduction in health care costs by the year 2000.

Mr. THOMAS. Well, then let me ask the question in another way so that we can get at what I consider to be an inherent internal conflict. I need to know whether you agree with it or not.

Do you believe that the goal of universal coverage and cost containment are at odds with each other?

Ms. SHEARER. No, I do not. I believe that the important thing to consider is not the amount of spending that we have in the private health care system, it is not—the important figure to focus on is total health care spending.

When people don't have insurance, it doesn't mean that they get no health care. It means that their health care is coming out-of-

pocket in a very regressive way. And we are interested in the total health care costs.

Mr. THOMAS. We understand all of that. But even Dr. Reischauer of the CBO, who has to control the numbers, has said repeatedly that you cannot have a plan as outlined by the Clinton administration which promises universal coverage and cost containment for the amount that he indicates. You can't do both.

If you are going to have universal coverage, it is going to cost more. You can't save money in the system and cover more people.

Ms. SHEARER. Well, again, I think it is important we use——

Mr. THOMAS. There are more or's in there than there are and's.

Ms. SHEARER. We think the important standard here is a single-payer bill, and that bill is able to achieve universality and cost containment in a way that no other bill on the table appears to.

Mr. THOMAS. I understand that. But if you want to hang on the position, as the chairman has clearly indicated, you are not going to be a player in this initial round of trying to determine how we change the health care system.

And if that is going to be your position, fine. Then I understand and know how I need to deal with you. That is, you're not going to be a player.

Ms. SHEARER. And if I could just modify my answer. I do want you to understand that we believe that the President has given us a plan that we can work with, and we will work to improve it and bring it closer to the single-payer ideal.

Mr. THOMAS. Mr. Dorn, the same things in terms of you with terms "sweet and sour," I don't care what you do, just leave the MSG out.

The problem is, as you go through, everything that you have talked about, which may be laudable, costs money. The price tag on yours, have you costed yours out? And the answer is, no.

And let me tell you, I have a lot of sympathy with you, because, as we focus on the delivery of health care or the nondelivery of health care to the poor, the gentlewoman from Connecticut and I have in common concerns about the poor. She has urban, I have rural poor. There are some commonalities. There are also some significant differences in the way in which we deal with it.

And that, at some point, we are talking about trying to provide something, rather than making sure that there is uniformity across the board. Your model is a laudable one. Let me tell you, when you run it through the cost factor, it is out of sight.

Mr. DORN. Well, Congressman, in terms of the issue of cost, I think in terms of the four points I was making, the last two are ones that involve dollars. The issue of cost sharing, where we are arguing that cost sharing for low-income people should be controlled, and the issue of supplemental benefits, as are currently being provided under Medicaid.

And in terms of cost sharing, relatively little research has focused specifically on the issue of primary care copay as applied to an indigent population, which is the issue that I am raising, not middle class folks, an indigent population.

There was one important study on this done in 1978 by the RAND Corp. which took a look at what happened in California when, in 1972, a \$1 copay was applied to the combination of the

first two physician visits per month. They found that, in fact, that increased systemic costs. That physician visits went down by 8 percent. Inpatient hospital costs went up by 17 percent, and overall systemic costs went up by 3 to 8 percent.

So our contention is that the best way to—one of the ways to control costs is make sure that low-income people get primary care early on, and don't go to hospital emergency rooms. And if you want to encourage that result, low copays will save you money.

Mr. THOMAS. And part of the problem is that we have a number of studies that prove a number of things, some of them diametrically opposed. And all of us are scraping for realistic numbers and statistics and figures to try to make sure that, as we make these changes, we understand what we are doing.

To me, one of the biggest problems is the fact that we are dealing with a product area in which, Ms. Shearer you probably agree with this—that we have probably the most uninformed consumer of virtually any purchase that we make. The job of trying to get that consumer more informed is fundamental. Yes, you have people who fall out of the system; yes, you have people who can't afford the opening bid, whatever the opening bid is.

But the primary problem right now is that the massive number of Americans who are covered may be concerned about whether they keep the coverage. Most people are generally satisfied with what they have. The problem is they have no idea what it costs to deliver what they have now. That is going to have to be a major component in whatever we do, and that is educating the folks we have.

And, Ms. Cain, I am a little concerned with your testimony. I will take you in the order that the chairman recognized you.

So very quickly, Mr. Kirsch, you know you talk to the State folk and they are more than willing to set up, run, control, and dispense the money. They only want the Feds to pay for it.

If you are looking for some kind of a uniform quality, you really can't turn the States loose. And what do you do with these States who decide maybe they don't want a single-payer involvement, such as Maryland wants? Some States have clearly indicated to us they don't want it. Surprisingly one of these States is Wisconsin.

You would think, from a political profile and a past history, that would be one they would tend to look for. The problem is, if it is a Federal problem, it needs a Federal solution. And we are going to be wrestling with all of that.

But interestingly, on page 4 of your testimony, where you offer a very simple solution to what is a very vexing problem for us, and that is where you talk about making premiums affordable under the Clinton plan. It just struck me that your approach was not only not novel, it isn't something that is supported in a number of areas in the world today where it was at one time.

What your plan basically says is that what you want in terms of payments are from each according to their means, and in terms of delivering the health care system, to each according to their need, devoutly to be wished by all of us. But somebody's got to pay the piper. And that is going to be the most difficult thing to do.

Ms. Cain, you know, I appreciate your cataclysmic outline of the problem. It is very dramatically delivered. I am telling you, nobody

that I have talked to, including the President, believes that the system is as broke as you say it is. There are a number of areas that need fixing. There are a number of areas of adjustments. But even in the President's plan, he keeps virtually everything we have and provides an overarching bureaucracy that runs it in the way that he thinks it should be run.

Where do you believe the President and almost all the experts are wrong in terms of indicating that the system is failing, that it has completely run amok, and that we need to fundamentally rebuild it?

Because if you believe that, as your testimony indicates, then you are not very supportive of the President's plan because he doesn't bring about a fundamental wholesale restructuring.

Ms. CAIN. What we mean by wholesale restructuring and fundamental changes is that we must have universal access, which means that the 37 million Americans who currently have no coverage will be covered. To us that is a fundamental, serious flaw.

Mr. THOMAS. But on the other side of the coin, more than 200 million Americans are covered.

Ms. CAIN. We also believe that cost—

Mr. THOMAS. Isn't that true? If 37 million Americans aren't covered, how many are covered?

Ms. CAIN. That debate can be—

Mr. THOMAS. It is not a debate. It is a math problem.

How many Americans are there? 280 million. How many are not covered? 37 million. What is left over? The vast majority are covered.

Ms. CAIN. We are concerned with the humaneness of a system that will leave people out and base health care on ability to pay as opposed to other factors. We would like to have the system changed. The crisis to us is that it must be changed; and this is a major step to include these 37 million people.

We also believe that the skyrocketing cost of health care—we have heard from many of our members and other people who have testified across the country about their inability to get health insurance—even from their employers and from the employers who say they want to provide health care but aren't able to. We see that continuing to change so that cost control mechanisms will indeed help.

Our members felt it was a crisis. It was a crisis based on their personal individual experiences as well as the experience of others. Maybe our perception is different than others.

However, we do feel that there are monumental problems. And we don't think that any reform that does not guarantee coverage or that does not include cost containment is real reform.

Mr. THOMAS. I understand that. That isn't what I got from your testimony. Your testimony was that the system is a complete failure and it needs fundamental reform. I will tell you, when you begin pushing not the 37 million who don't have it—because most of the public understands that the Clinton plan helps people who don't have it and who are basically poor. That is a positive. Everybody supports that.

But you have got to deal from a political point of view with all those people who do have something. You have got to eventually

bump into the question of choice and quality when you begin to talk about a fundamental restructuring. It is just that very easy to paint it in cataclysmic terms and make ringing statements as though we are dealing with a revolution. In fact, what we are doing is trying to, without doing any new harm, make adjustments in a system that is \$1 trillion of this economy. The worst possible thing would be that the majority of people who already have coverage and are basically pleased with it, wind up saying that I am paying more and getting less. That is unacceptable because then you have a real political problem on your hands.

We are going to try to work together on it. I just think if everybody lowers the flame in terms of what the problem is and how to solve it, we will have a better chance of coming together, instead of deciding that it is all black or all white and if you don't do it my way, then you are not doing it the right way.

And to that point, Ms. Cain, on page 4 of your testimony, you talk about the inclusion of reproductive rights, especially abortion services in that basic health care package.

The question I asked the other panel, I will ask you: If it isn't included in the package, does this mean you oppose the package? How central is it to your support of the package?

Ms. CAIN. Removal of reproductive services would be very serious—

Mr. THOMAS. Reproductive services I think we can keep in there in terms of counseling and other things. I am talking about the funding of abortions, extending to voluntary abortions, as part of the basic package.

Ms. CAIN. The basic package includes abortion services. Their removal would be a serious consideration for us and we would have to give it serious consideration as to whether or not we would continue to support the plan.

Mr. THOMAS. So you wouldn't oppose it—so you wouldn't oppose it automatically?

Ms. CAIN. We would see it as a step backward. Currently, insurance companies provide abortion services, so if we are not going to continue to provide them and cover them, it would be a serious step backward in our mind, and we would have to take a serious look at what kind of proposals we would support without abortion services.

Mr. THOMAS. What did you mean when you say "insurance programs offer it"? Certainly there are some who have it, some who don't. It is determined by the employer-employee relationship. Sometimes it is included, sometimes it isn't, sometimes for cost reasons, sometimes for choice reasons.

You are saying that it has to be in there mandatorily for everybody. That is different than your support you just gave in terms of evidence that it should be there.

Ms. CAIN. We support its inclusion, and we will do everything we can to see that it is included in any package.

Mr. THOMAS. If it is a rider, it is going to be a relatively cheap rider. From a political point of view including it, are you willing to risk losing most of what you indicated you think absolutely needs to be done in terms of fixing this crisis facing America? If you don't

have the abortion services in there, will you fundamentally re-evaluate this otherwise fundamental restructuring of the system?

See, I am trying to get a feel for how critical it is to you, and you are telling me it is very critical.

Ms. CAIN. Yes, sir.

Mr. THOMAS. I am trying to tell you about that from a political point of view, it probably isn't worth it in accomplishing 99.5 percent of everything else you said absolutely is necessary for the future of America, just from a political point of view.

Thank you.

Chairman STARK. I hate to risk what I suspect is a record, but I would not have to be second to anyone in my support of reproductive choice. But with a very, very sick feeling, not from Mr. Dorn's gastronomic escapades here, but from the fact that I think my colleague from California is right. I suspect that later today we are going to go through an exercise on the floor of the House and add back restrictions on abortion for the people in the District of Columbia.

I just guess I ought to put all the groups on warning that I am going to hate to kill the better with the best. But we may lose for reasons that have nothing to do with health care reform or anything else, when at some point in this debate somebody is going to offer a restriction on abortion. And that is going to be an issue whether or not we have the votes. I just hope that we all can recognize that, isolated as an issue, that politically has nothing to do with providing health care, and work on those who may vote one way or the other. I say that it is not the kind of thing I like. But there is so much else in here that we must do, that is an issue that I would hate to see people, whose agenda has nothing to do with health reform, stall this or destroy whatever compromise we could reach through that.

Mr. THOMAS. Mr. Chairman, just briefly on that. And let me put the wording in a different form because I left it open-ended.

I would urge everyone not to make that linking statement between the abortion portion and this overall fundamental reform. Because to the degree that you do that and your support is contingent upon that, those people who don't share your opinion on all those other areas are strengthened by dealing with that abortion provision, which then triggers an enormous negative reaction to everything else that you have.

And it is a relative risk gain. And I would ask that no one be absolutist in their positioning of these two issues, because if you are, you will actually strengthen the hand of the people who are opposed to what you want.

Chairman STARK. Deal with it in subsequent political campaigns. There is a way to deal with that, in my opinion at least, separately.

But I do have some more questions for the panel, just very quickly. First, I would ask, three of you, I think, with the exception of Ms. Cain, that you all have endorsed a single-payer system. And I think each of the three of you, Mr. Kirsch, Mr. Dornan, Ms. Shearer, referred at least in spirit to Congressman McDermott's bill.

And so often the critics of the single-payer bill will ask what is it and Canada comes up. These knee jerk reactions. For those of

you who advocate Mr. McDermott's bill and H.R. 1200, wouldn't you say that it is a fair proxy to suggest in this country that Medicare comes as close to being a single-payer system as anything we could describe to people?

Is that a fair characterization of a good single-payer system?

Ms. SHEARER. Yes. If I could start, Chairman Stark, yes, I think that the debate would actually benefit from more discussion of Medicare, which is a very popular program among our senior citizens.

The one key thing that varies between Medicare and H.R. 1200 is the extent of deductibles and coinsurance under the Medicare program. And I think that is something that—

Chairman STARK. It is not perfect, but I am just saying what we know. And there is a great deal of misinformation about Canada and the Canadian system, mostly generated by the A.M.A. and others who would not like single-payer.

There is some misinformation about Medicare, and I am just trying to frame some examples or anecdotes for people.

And I would ask—Mr. Kirsch is nodding, so I will ask him next—if you are comfortable with that.

Mr. KIRSCH. Yes. In fact, I usually don't talk about Canada because you get into these arguments which really are beside the point.

As I look at H.R. 1200, in many ways it is an improved version of Medicare for all, with some very important improvements from which everybody can benefit. And if you go to a group of senior citizens and say, would you want to trade your Medicare card for private insurance, the answer is, uniformly, no.

Chairman STARK. You can't even get a Republican to call Medicare socialism.

Ms. Cain, I don't want to get the League of Women Voters into a position that you say they haven't taken. So let me skip to Mr. Dorn, whose group I suspect would support a single-payer system.

Mr. DORN. We sure would.

Chairman STARK. Would Medicare be a fair representation of a type of single-payer system?

Mr. DORN. Absolutely. And I think its advantage politically is people have direct experience with it and it is harder to mislead folks than it is even across this near-Canadian border.

Ms. CAIN. Mr. Chairman, if you don't mind, I would like to respond to that.

Chairman STARK. All right. Weigh in here.

Ms. CAIN. Our membership does prefer a single-payer system. The League does find, however, an employer-mandated system acceptable if we are moving toward that goal. So we do prefer single-payer but find employer mandate acceptable.

Chairman STARK. Would you feel in your personal opinion that Medicare is a type of single-payer system?

If you were saying to somebody, give me an example of what a single-payer system is like, would you—

Ms. CAIN. Well, we would support the bill as people have indicated here as an example of a single-payer system.

Chairman STARK. We have had a lot of suggestions that we take the approach promoted by the Golden Rule Insurance Co., who, ac-

cording to their recent ads, Ms. Shearer, has said is the most efficient or one of the most efficient life insurance companies. I got to go back again. I know that can't be true. But that is instinctive.

And there are certain sets of Republican bills that promote medisave accounts, that is, you get to save the money and you buy a catastrophic plan that will cover everything over say \$3,000, and you are on the hook for the first \$3,000. And the way we get you to put away the first \$3,000 is to give you a tax exemption or a tax deduction for this little medical IRA.

Could you quickly, each of you, give me your opinion of that option?

Ms. SHEARER. Sure. We believe that medical savings account, that approach, would be a major step backward when it comes to universal access. It could represent employers cutting back on the health benefits that they provide now.

Our experience with IRA accounts, typically higher income people can afford them, but not lower-income people.

Also, the medisave accounts tend to be linked in legislation with an approach of catastrophic health insurance, which means people would be getting less preventive care. Total health care costs could go up. So we have major reservations about that type of approach.

Chairman STARK. Mr. Dorn.

Mr. DORN. I would join in all of the comments that were just made, and I would add that the folks we represent, low-income people, don't have the money to put aside in those accounts. They don't even have the money to buy bread and groceries sufficient to feed their family.

Chairman STARK. I have a hunch they would toss them a loaf or a fish and say something about under 150 or 200 percent of poverty, they get something. But I never got that far in the small print.

Mr. DORN. Well, you know, the question of getting a little something—I mean if you get a catastrophic policy, you don't get that basic primary care that you need; and it would take loaves and fishes and miracles to make sure that our clients would get services they need under an approach like that.

Mr. KIRSCH. Medisave accounts don't help the people that are currently underserved. It is not just the people Stan is talking about, not just the poor. People make \$25,000, or \$30,000 working several part-time jobs, yet they don't have the money to put aside—money for such accounts.

And under such a plan, if they scraped up the money—which they probably couldn't—and then have the high deductible, they couldn't use that money to feed their family or pay a car loan if need be. It is crazy.

Ms. CAIN. We would concur with the statements that have been made.

Mr. THOMAS. Mr. Chairman, I apologize. I wasn't here when the questioning went toward the concept of medisave.

Chairman STARK. Yes. I just asked them their opinion of medisave.

Mr. THOMAS. As a required system or as a voluntary one?

Chairman STARK. Someone has suggested that we take the approach as promoted by the Golden Rule and the Senate Repub-

licans to promote medisave accounts. What is your view of this option. That is what I asked them.

Mr. THOMAS. What I wanted to ask was, in their mind, when they answered that question, did they see it as a required position or one that would be optional and available to those people who chose it in terms of their response?

Was their response tied to a requirement that it be there or that it be optional and people could choose it if they want to but would have a full panoply of the other choices?

Ms. SHEARER. Yes. The key question for us is, is it linked to a universal comprehensive program where everybody is protected? If it is a little something on the side, it is one issue. I mean what we want to see is everybody covered by a health plan. We don't think that medical savings accounts are going to provide the protection that Americans need and want.

Mr. THOMAS. Alone? You wouldn't be opposed to them if they were offered as part of a program for those who chose to utilize them if the other aspects were present as well?

Would you purposefully exclude them?

Ms. SHEARER. Yes. Yes, we would. Because it has a potential of undercutting the notion that we are all in this together. We want to avoid people having catastrophic care only and then possibly—

Mr. THOMAS. Well, wouldn't that same argument extend to a fee-for-service option as well?

Ms. SHEARER. No. If everybody has the same basic benefit package, they choose to go to different plan approached to implement it.

As I understand your proposal, you are suggesting that some people would opt out and would not have a basic benefit package but only an IRA account and possibly catastrophic policy.

Mr. THOMAS. If they chose that route. I thought, interestingly, earlier you indicated that you agreed with me that informed consumer is one of the biggest problems we had in the system.

Some of us think that if, for those people who wish to take that option—not required, not mandatory, not the only solution in the system—that the kind of people who would choose it are those who tend to be careful about their preventive care, wish to control as much of their health care dollars as possible. By wise and prudent choices, they could succeed in doing so and that if they choose that option, that would be their choice. We think that would be a useful thing to have available. Not mandated, not exclusive.

Ms. SHEARER. OK. I think—we certainly don't have evidence that indicates the profile of people who would choose them tend to take care of their preventive health better.

What we would be concerned about is the problem we have in the system now is that healthy people, people that perceive they are healthy are able to opt out and not pay premiums. We believe that health care reform requires a mandatory, everybody-is-covered type of approach so that everybody is paying in one way or the other and everybody is covered.

We think that a voluntary opt-out-type of approach, as suggested along these lines, would create problems of selection, selecting out perhaps the healthy, perhaps people who need to be putting in their premiums, their tax dollars into the program for everybody.

Mr. THOMAS. If they paid all the money that is supposed to be paid and then choose this option, which in fact costs them money, would you be willing to do that, just as you have private schools as long as people pay their taxes and cover the public schools and then send their children with their own money?

Chairman STARK. I could say the line of questioning is that I might stipulate to my ranking member, that if we had a mandate for union verbal coverage and we were able to find a way that we could agree on the controlled costs, I always suspect there will be, in every law, in every plan, 5, 10 or 15 percent of the people at either end of the scale for whom our overall plan will be less than satisfactory. And, as they do in Germany, still 12 or 15 percent, there they say you have to have more than \$30,000 in income before they will let you opt into the private plan.

So I think I could stipulate to the gentleman that we could find a way for those who have some burning philosophic concern or creative concern to be in another plan, as long as it didn't hurt the others we could find a way to do that.

I wanted to go on—

Mr. THOMAS. Let me say, I appreciate the gentleman's statement, because that is the political answer.

You folks are continuing to operate in a theoretical model in which you viewed real political solutions.

Chairman STARK. We don't want them running against us, Mr. Thomas.

Mr. THOMAS. Please consider your statements in the light of us having to get 218 members to approve a plan.

Chairman STARK. I would like to go on to one more, because I know that there was a comment by one of you on regressivity of a VAT or a sales tax.

And I must say, I am concerned with regressive taxation myself, but I also have a sense that perhaps the denial of benefits is even far more regressive than a couple of points on a loaf of bread. If I got toward the end of the string here and saw adequate coverage for all, I think it is 240 million Americans—I think my colleague just let in a lot of illegal aliens into his part of California, he says 280 million—but whatever it is, I am willing to accept.

But having said that, I think that we will come at the end of this procedure. And, assuming we dispense with reproductive rights and opt-outs for the independent livers, we are going to have to pay for something.

And the question is, do any of you have a type of financing, a sales tax, a tax on providers, a payroll tax, gasoline tax, spot me \$1 a pack on cigarettes? That is probably only \$15 billion a year; that is not going to do it.

I am thinking that we are going to need in the nature of \$50 to \$100 billion depending on how fast it is phased in and how generous the benefit package is.

Could you just quickly, in summation, tell me what your favorite tax that you think I can sell. I mean I have to get Thomas to vote for this tax.

Now, Ms. Shearer.

Ms. SHEARER. Yes. Our preferred means of paying for health care is through increased payroll taxes and increased income taxes. We

do not like the value-added tax. We feel the administrative costs needed to make it anything close to proportional as opposed to regressive are extremely high.

Chairman STARK. How about just a sales tax?

Ms. SHEARER. That is right.

Chairman STARK. No. I mean how about just a good old sales tax?

Ms. SHEARER. They tend to be very regressive. On the other hand, we do support regressive taxes which are the cigarette taxes, alcohol taxes, and firearms taxes as means of raising some revenue.

We have to be realistic here. We are not talking about financing the whole health program by these sin taxes. But we do support them as one part of the finance package.

Chairman STARK. Mr. Dorn.

Mr. DORN. Chairman Stark, obviously low-income people are bearing the brunt of these different funding mechanisms. But given the choice between bearing that burden and not receiving health care or not receiving adequate health care or having to pay too much for it, I would opt, in a minute, for the revenue, and so would our clients.

Chairman STARK. Great.

Mr. Kirsch.

Mr. KIRSCH. Clearly, we favor broad-based revenues such as increasing contributions on a proportionality basis from employers and employees and progressive income taxes.

Your point is taken that the system we have now, financing health care, is very, very regressive as are many of the proposals that are being introduced.

And so if the question was: Can we provide the kind of comprehensive coverage to everyone based on the taxes that we have? We would have to give our members that tradeoff, and it would be a tradeoff. We think there are other options that are preferable.

Chairman STARK. Ms. Cain.

Ms. CAIN. Yes. When we did our study, we asked our members specifically, were they "willing to pay more taxes for comprehensive health care reform?" They said, indeed, they were.

Our preferred method is through an income tax. We are opposed to a value-added tax, and we, too, hold strong on the sin taxes and would hope that you would hold tough on the amount.

Chairman STARK. When you polled your members and they indicated a willingness for an increased income tax, did they quantify that?

Ms. CAIN. Yes. In response, they want comprehensive reform, which to us means—

Chairman STARK. How much are they willing to pay?

Ms. CAIN. Oh, no. There was not a specific number tied to comprehensive reform.

Chairman STARK. Unfortunately, polls have shown a willingness on the public in general. But when you force the question, as the poll officers will, once we get up over that \$2 a month, we run out of enthusiasm, about at the same time we run out of money. So it is still a problem.

And I do appreciate the suggestion that there is some room for compromise. I can justify it in my own mind that it is among the most regressive problems that people face in life, the absence of medical care, which often is a cliff, regressive sales taxes are at least linear in how they impact on you.

But the other side might be worse, and I appreciate your willingness.

Mr. DORN. Chairman Stark, if I could just add one comment to what I said a moment ago. I think there are ways to structure these revenue streams to reduce the impact on some of the poorest people. For example, exclusions from the sales tax of some of the basic necessities of life.

Mr. THOMAS. One followup in terms of where we are getting the revenue.

Do you believe that over a 5-year period you can get \$240 billion out of Medicare and Medicaid by squeezing out waste, fraud, and abuse?

Or another way of saying it—well, \$124 billion out of Medicare and \$114 billion out of Medicaid. That is \$240 billion over the next 5 years, squeezing out waste, fraud, and abuse, and a 50 cent tax on tobacco, which is the President's proposal to pay for the plan.

Do you believe that is honest and realistic and doable, squeezing out waste, fraud, and abuse to the tune of \$240 billion and a 50 cent tax and tobacco, yes or no, down the line?

Chairman STARK. If the gentleman will yield, it was more than waste, fraud, and abuse. It was reducing payments as well.

Mr. THOMAS. I understand. I understand reducing payments. But that, then, gets you into the quality part of it.

Chairman STARK. But \$240 billion was not all on waste, fraud, and abuse. It also included lower payments.

Mr. THOMAS. And I would ask my Chairman to go back to the September 22 address of the President to the joint session of Congress, and you will find precious little reference to that and a heavy, heavy dose of waste, fraud, and abuse. So I will concede \$40 billion out of that, \$200 billion in waste, fraud, and abuse.

Back to the original question. Simply, yes or no, do you believe the President's funding mechanism will work or do you believe Senator Moynihan, it is a fantasy?

Ms. SHEARER. That is a tough yes or no. Closer to yes than no.

Mr. THOMAS. Mr. Dorn.

Mr. DORN. May I give more than a yes or no answer? I think it is an important question, and I have some thoughts.

One—and we focus more on the Medicaid program than the Medicare. First of all, I think there are ways to achieve fixing the Medicaid program. In particular, the Boren amendment passed in the early 1980s has provided a tremendous amount of money to hospitals and nursing homes. I think it is worthwhile taking a look at that.

Mr. THOMAS. Nobody disagrees with you that we can get money out of the system. The question is, over 5 years, can you get \$200 billion-plus with waste, fraud, and abuse?

Mr. DORN. Let me lay out my concern about the President's approach in terms of Medicaid. As I understand the folks from the administration, their theory is, if we bring inflation in the private

sector under control, then those savings will translate into savings in the Medicare and Medicaid programs. And I think that may well be true.

But our concern is that, if the private sector controls fail, Congress can turn the tap on Medicare and Medicaid. That is in the Congress' exclusive control. And we would fear a situation where private sector costs continue to escalate and Medicaid costs get cut with caps put on.

Mr. THOMAS. Well, and what you've just stated is a very real concern of all of us, because every year we have moved toward trying to reduce the deficit by making cuts in—principally Medicare.

Those imbalances are going to continue over those same 5 years that he is going to be getting his money to fund his system. No one has yet explained to me where we are getting the other money to continue to do what we used to do with the Medicare money, and that was play with it in this committee to reconcile the budget.

Mr. Kirsch.

Mr. KIRSCH. We believe it is possible to, if you slow down health care inflation in the entire system at the same time, we believe you can do that in Medicare and Medicaid. It is not just waste, fraud, and abuse.

If you look in the plan, there are specific items like changes in provider payments, copayments, some of which we would favor, some of which we wouldn't. But the basic fact is those aren't cuts, they are slowing down the rate of inflation. We think you can slow down the rate of inflation provided you provide the right incentives to do that.

Mr. THOMAS. You had that chapter and verse.

Go ahead.

Ms. CAIN. We have not done a statistical analysis to answer you directly. We do believe that there can be some cost savings. What they are, we cannot quantify for you exactly. Our members have said that, after you contain costs, we are willing to pay more taxes if that is necessary.

Mr. THOMAS. I won't spend time on the tax, but let me tell you, at some point in this system, we have got to examine whether or not we are going to go against the rest of the world and continue to base virtually all of our payments, including this enormous new entitlement program, on income tax. When somebody already has a program and you are going to get him, through the income tax to pay for others, they are going to say, I am paying more and getting less and you have products coming into the United States that are not taxed as opposed to our products going into the other countries.

To a certain extent, we have got to look at the way the rest of the world is acting. We either continue to swim upstream or begin to talk about conformity. When you get into the real world trade-offs, the idea of simply saying that it is going to be payroll or income tax and that you refuse to look at other options because they are, "regressive," either in terms of replacement revenue for the way in which we charge things or new revenue, you fall into the trap of arguing that our system is, in fact, a good system vis-a-vis the rest of the world in taxation. We simply do not do what the rest of the world does. What we do, worse than anybody else, is tax sav-

ings, tax investment, and allow goods to cross our borders that we pay the health service costs of other countries through. We don't have those other countries helping to share our costs.

Once again what I hear is primarily some knee jerk reactions in terms of types of tax systems, instead of taking a look at the problem that we have. I don't know why in the world you move so readily away from a suggested change in the tax system that would help Japanese and Germans pay for American health care costs, when Americans pay for Japanese and German health care costs by virtue of their tax system.

And I guess, Mr. Kirsch, you are willing to say that Senator Moynihan was way out in right field when he said that the Clinton financing system was a fantasy.

Mr. KIRSCH. Let me comment that in terms of international competitiveness, our businesses are paying, in effect, a very large tax for health care. We had a person in our polling study who paid 19 percent of his payroll for health care.

Since the President's program is bringing that down to 8 percent, though that figure may be too low for us to afford it, we are going to increase international competitiveness tremendously with his plan. There are no savings like that in the Michel proposal or Cooper-Grandy proposal.

Mr. THOMAS. Since I get the last comment—and this will be the last comment, Mr. Chairman—I don't know anybody who believes that business pays for anything. I constantly have to remind my friends in the business community of this. Business doesn't pay for anything. It is like government, government doesn't pay for anything; business doesn't pay for anything. It either comes out of an increased cost to the consumer in the product or reduced profit to the owner in terms of dividends or out of the employee.

And I have seen some very persuasive studies that show over the last 20-year period, especially when there were increased costs in fringe benefits and the employer-employee using the government to hold the bag in increased fringe benefits because of no caps on the taxes. That, adjusted for inflation, total compensation, wages, and fringe benefits, have gone up 12 percent. Hourly wages adjusted for inflation over the same 20-year period went down 6 percent. Business isn't paying for these increased costs. The employee is, as is always the case.

Chairman STARK. I want to thank the panel. I would say that a bill that was introduced by the majority leader and myself in the last Congress did score, by CBO, \$300 billion a year by the end of the decade in savings, \$200 billion of that went to the private sector, and \$100 billion a year was in the public sector, Medicare and Medicaid, by virtue of restricting the payment structure in this country to the Medicare and the private sector rates but limiting the inflation rate from 10 percent, ratcheting it down to 6 percent over the period of time.

Now, although we got CBO scoring, there is no scoring as to what that might or might not have done to quality and the rest. And that is the concern. I think that we can find the savings in the aggregate if he can mandate it.

But the concern I think of this committee and the panel, the ranking member and myself, is the unintended results of those savings in a complete system.

And I appreciate the gentleman's raising that issue. And I thank the panel very much. I hope, as I suggested to the other witnesses, that you won't be bashful about coming forth to us formally or informally over the next year as we work on this problem, because your testimony and your concern is appreciated.

Thank you very much.

Our third panel today will be comprised of a variety of special interests who have a very important role to play, other than just trying to destroy the President's plan. I want to welcome Jeff Smedsrud, who is the executive vice president of an organization called Communicating for Agriculture; and Dr. Richard Ehrenkranz, public policy fellow, with the March of Dimes Foundation; and Daniel T. Bross, who is the executive director of the AIDS Action Council.

Welcome, all of you. Please proceed in the order you were announced.

Chairman STARK. Mr. Smedsrud, please proceed.

STATEMENT OF JEFFREY SMEDSRUD, EXECUTIVE VICE PRESIDENT, COMMUNICATING FOR AGRICULTURE

Mr. SMEDSRUD. Thank you.

Mr. Chairman, members of the committee, my name is Jeff Smedsrud. I am executive vice president of Communicating for Agriculture, which is a national rural association that represents some 80,000 farmers and ranchers and rural small businesses. We have been involved in health care reform for a number of years.

This week we brought the State directors of the 27 programs that provide services to those that can't get insurance to Washington, D.C., for our annual conference.

Last week we brought about 110 farm leaders from around the country in to look at the various aspects of health care reform.

Recently, we did a survey of farmers all around the country regarding their attitudes on health care reform. Let me just point out some of the very sharp differences that existed between those who said they voted for President Clinton, those who voted for Bush, and those who voted for Perot in regards to what they see as their problems in health care and how they would expect to solve those, as well as some very significant differences between men and women who responded to health care questions.

I am going to deviate a little bit from my written remarks.

We believe there are distinct advantages to businesses and individuals to pool together in health cooperatives. Farmers believe in co-ops, businesses form purchasing groups; consumers have created buyers markets. We think they ought to continue to push for and build those cooperatives.

We have a lot of trouble with the President's plan in the way in which his alliances or "cooperatives" work in the plan, as best we all understand it. We think it suffers, quite frankly, from an intellectual disconnect in terms of how those alliances would or would not work. Those alliances are often described as warehouses where everybody would come in and purchase health plans.

The reality is that in many instances those alliances would have the opportunity to select only one plan in rural areas. They could decertify plans. They would do risk adjusting amongst plans. They would make sure that plans meet certain standards. They would offer data and quality information.

In essence, those alliances would have not a little bit of authority and power. They would have a great deal of authority.

We would suggest that as an alternative there be multiple and voluntary alliances that would be working alongside the regional alliances.

Now, those in the administration who say that is not a very good idea to have voluntary multiple alliances point out that this would lead to some sort of risk selection. If there were voluntary alliances, there are risk adjustment methods that could probably be utilized. Those who would suggest that those risk adjustment methods don't work ought to also look at the fact that they would be using the very—

Chairman STARK. Could I go back just a minute, because we were talking about that before the hearing this morning.

You don't mind the alliances as long as they are voluntary, is that what I understand?

Mr. SMEDSRUD. I would create a series of voluntary alliances.

Chairman STARK. Anybody could come in, co-ops could come in. But you are saying the administration told you that would create a different kind of risk selection?

Mr. SMEDSRUD. That would create a risk selection.

Chairman STARK. And there wouldn't be risk selection in a mandatory alliance?

Mr. SMEDSRUD. Well, they said they would have risk adjustment procedures in a mandatory alliance. My response to that is if you are going to use the risk adjustment procedures in a mandatory alliance—

Chairman STARK. Did they outline for you this risk adjustment procedure?

Mr. SMEDSRUD. No. No one has outlined this. I testified yesterday before the Senate Labor Committee—

Chairman STARK. Do you remember Paul Bunyan?

I think he was from your State.

Mr. SMEDSRUD. He was from my State, correct.

Chairman STARK. I think he knew about risk adjusting. Babe knew about it, but they didn't pass on the secret.

OK. Go ahead.

Mr. SMEDSRUD. The point, quite frankly, I am making is that if there is risk adjustment in the mandatory alliances, then risk adjustment must work; and, therefore, there ought to be allowed risk adjustment in voluntary alliances.

If risk adjustment doesn't work in the mandatory, it won't work in the voluntary either. But if it works for one, why wouldn't it work for the other?

Chairman STARK. Makes sense to me.

Mr. SMEDSRUD. The point I would make, to continue on, the surveys that we have been doing, the talks that we have been giving, poll after poll confirms the obvious, that the more people hear about the plan as it is structured, the more confused we all get.

Our efforts in working with farmers is to try to determine what types of reforms there need to be. On the broad principles there is hardly any disagreement at all. How we get there is where everybody disagrees.

I would like to conclude by walking through five or six concerns that we would raise on behalf of rural America about the way the President's plan is structured at this point.

First, we question whether or not the standard benefits are, indeed, too good. We think there ought to be a little bit more flexibility in defining those benefits and in particular as you get to the point of costing those things out.

Second, we have a real serious question: Will rural subsidize urban? If you put everybody in a single State in one alliance and say everybody ought to be charged the same, basic medical costs are less in rural communities. If you put rural and urban together, you are indeed going to have rural subsidizing urban.

Third, we question will fee-for-service plans, structured within the framework of the rules that the alliance would have, be a viable option?

We also question, although the alliance says you will have a choice of plan, if that alliance has the right in rural America to select one plan, if it has the right to decertify a plan, if it has a right to cap enrollment in a plan and put you in a plan not of your own choosing, we really wonder what kind of choice we really have when it comes to fee-for-service plans.

Fourth, I would look at the economic impact on rural communities. We believe in forming cooperatives. We believe in a sort of bottoms up approach to reform. But if the effort is to achieve efficiency by having that alliance exercise whatever power it can to make bigger and better systems, what is that going to do to small town hospitals in rural communities and rural clinics?

I would raise some questions about some of the incentive programs, the way they are structured.

And finally, on behalf of rural people, I would raise a lot of questions about the makeup of a National Health Board. Seven people on that National Health Board would have enormous powers. What guarantees can we have that minority interests, such as rural interests, get a fair shake from these seven people?

Quite frankly, you can say, well, we will make three rural and four urbans. But it is four against three. And you can go on and make it four rural versus three urban, and you would have the same argument. It is a lot of power in the hands of a very few people that don't have a very good understanding of the distinct differences in the delivery of health care and the access to health care that exists in rural America.

With that, I would be happy to answer questions at the appropriate time.

[The prepared statement and attachments follow:]



COMMUNICATING FOR AGRICULTURE
2626 E. 82nd Street
Suite 325
Bloomington, MN 55425
(612) 854-9005
1 800 445-1525

**Testimony of Jeffrey Smedsrud,
House Ways and Means Committee
Oct. 21, 1993**

Mr. Chairman and members of the committee, my name is Jeff Smedsrud, and I am executive vice president of Communicating for Agriculture, a national rural association that represents about 80,000 farmers, ranchers and rural small businesses.

CA has had a long involvement in health reform. For 17 years we have helped create state risk pools for those denied insurance for health reasons. This week, we brought the directors of the 27 states that operate these programs to Washington, D.C., for our annual conference.

Last week, we organized a conference in Washington that was co-sponsored by 10 other national rural and commodity associations. More than 100 farm leaders worked together to examine the impact of various health reform proposals.

We recently completed an independent survey of America's farmers regarding their opinions on health care reform. Attached are results from that survey.

CA wants to ensure that the freedom to make health care choices is not a casualty of a reformed health system.

Let me be clear. There are advantages to business and individuals pooling together in health cooperatives. Farmers believe in cooperatives. Businesses have formed purchasing groups. Consumers have created buyers' markets. But always they do so with the belief that consumers — and not the government — will manage and run the cooperative or purchasing alliance.

Simply stated, mandatory health alliances are monopolies. Monopolies stifle competition. Lack of competition limits choices, and limited choice can reduce quality.

In my home state of Minnesota, the growth of voluntary health alliances is one of the reasons we have become a national model.

Let me review a few of Minnesota's shining stars:

— In Red Wing, a river town of about 15,000, a community-led initiative pooled large and medium-sized businesses together and improved care while bringing costs down. Why did they do it? Because smart-thinking local leaders knew that jobs were being lost, because more and more of the local health dollars were migrating to Minneapolis or Rochester. Pulling the community together and working with people to get their care locally put more money into the local economy.

In rural America, health care reform must be about jobs — creating jobs, not losing them in the name of large-scale efficiencies.

— Forty-nine rural hospitals — some of which are in North Dakota and South Dakota — are in the process of partnering with insurers and employers to create their own voluntary, regional alliance. The goal is to operate the plan as a true cooperative, and see 90 cents on the dollar go back to pay the medical costs. It eliminates duplicative administrative functions, and develops community profiles to deliver the types of services that best meet local needs. They will utilize data to manage costs and change practice parameters. No part of it will be based on risk selection.

— And finally, while many large businesses have for years formed powerful networks, a group called The Employers Association has pooled 80 small and medium-sized firms into a voluntary network. The result: a three-year guarantee of very stable prices.

Across America, new voluntary alliances — in many shapes and sizes, with differing names and structures — are changing the face of health care. We, the people, are forging our own American solutions to the health care crisis. And with common rules, standard practices and a level playing field, the people — and a reformed market — will continue to find better solutions than would ever be achieved by government monopolies.

Voluntary alliances can help solve the health crisis but only if they get a helping hand from a government that attempts to nourish change, not control it.

Without question, all Americans must have access to health insurance — and government must guarantee it.

Without question, there should standards for alliances — and government should write and enforce the rules.

Without question, tax policy should be fair and equitable — and government can make it so.

Without question, technology and data play significant roles in improving care and lowering costs — and government ought to remove barriers.

In short: Government doesn't have to run the health care system in order to make it better. Mandatory alliances will be giant, regulatory monopolies that will not serve the best interests of rural America. We will be better off if we grow our own solutions.

Out in the country, many farm and rural associations offer excellent plans. Groups like The National Association of Wheat Growers ... The American Soybean Association ... The American Veterinary Medical Association ... The National Grange ... CA ... to name but a few.

For many Americans, the message of mandatory alliances is this: You won't be able to keep the plan you now have, even if it costs you less and you like it more.

Instead of tearing down existing plans, why not use them as the base to do an even better job?

If pooling arrangements are working in the private sector — and in many cases they are — why replace them with a new government-sponsored system that is unproven?

When Florida reformed its health market it created new health purchasing pools. But it does not make them mandatory.

In California, many small companies are joining a new health insurance purchasing cooperative. The state chose to make the pool voluntary — not mandatory.

Texas and many other states are working to encourage purchasing cooperatives — but they won't be mandatory.

Let me give four sound reasons to encourage voluntary, competing purchasing cooperatives:

1. It maintains an employer's ability to control cost and retain a role in negotiating the best deal.

2. They retain freedom of choice. If the cooperative doesn't do a good job, people have the right to go somewhere else.
3. It puts control over how to solve health problems in the hands of local people and maintains existing, valued relationships.
4. It creates true competition on a fair and level playing field.

I'd like to conclude my remarks by highlighting several troubling points of the President's plan — in addition to the aspect of voluntary vs. mandatory alliances — that will be challenging for rural Americans. I raise six questions:

1. Are the Standard Benefits Too Good?

The President's plan will require all individuals to purchase a plan with generous benefits and low deductibles, and the plan will be community-rated. Farmers tend to buy a plan with high deductibles and "self-insure" for routine, nonemergency expenses. The President's plan means more insurance with more benefits, but it may also raise the costs for some. Shouldn't more individual flexibility be allowed?

2. Will Rural Subsidize Urban?

Because the President's plan would prohibit health plans from offering different rates based on geography, rural residents — where basic medical costs are less — may end up subsidizing their city cousins. States that have made progress on reform have acknowledged the need for urban vs. rural differentials as part of modified community rating.

3. Are Fee-for-Service Plans Really an Option? How Much Choice Will There Be?

Fee-for-service is still the primary option in rural America. Managed care has not been viable in many areas. Fee-for-service plans would be allowed in the President's plan, but only under a "single payer" fee schedule set by the alliance.

And even though the alliances claim to give choice of plan, if a plan wasn't successful in keeping its costs in line with other plans, the alliance could move people into more cost-efficient plans, against their will. In rural areas, the alliance may choose a plan for us.

4. What Is The Economic Impact For Rural Communities?

In the President's plan, large alliances will, in theory, hold down costs by improving efficiencies. Rural residents are worried about the likely transfer of jobs and medical facilities to regional centers, accelerating the demise of small town hospitals and very small communities. If small town hospitals — often the largest employer in a community — are forced to close, it will cause jobs to be lost, and diminish the prospects of bringing new jobs to the community. Funding for the President's plan comes, in part, from cuts to Medicare and Medicaid. These cuts will have a disproportionate impact on rural hospitals.

5. Will the Incentives For New Providers Really Help Underserved Areas?

Rural areas face a critical shortage of medical personnel, and the average age of doctors is higher than in urban areas. Incentives are clearly needed. However, some incentives in the President's plan are linked to the designation of an area as a federal Health Professional Shortage Area. Areas that meet the HPSA designation have access for incentives; those that just miss the cut-off do not. In addition, areas that use the incentives to recruit physicians face the loss of the designation after three years, creating instability to an already fragile system. In addition, the use of physician-to-population ratios as the measure to allocate resources may not always be appropriate

when the need, for example, is additional nurses or physician extenders.

6. National Health Board: Too Much Power In Too Few Hands?

Surveys by CA and others point out that people are skeptical both of too much government intervention and of too little. But what is the proper mix?

The President's plan would create a seven-member national health board that will have enormous powers. If states cannot live within budgets established for them by the National Health Board, the federal government could intervene and either move the state toward a single-payer system or impose new requirements on businesses and providers in that state. And how will minority interests — such as rural areas — be given a fair shake by a board that will likely be dominated by urban, large-scale interests?

The choice for rural residents is clear: We can either lead change by forging new, innovative, voluntary, local cooperatives or we can be herded into plans dominated, controlled or designed by others. Encourage health cooperatives, but let them be voluntary.

Thank you.



Survey of Farm Owners/Operators

Commissioned by:
Communicating for Agriculture

Completed by:
Minnesota Survey Research

October 5, 1993

A national telephone survey about health care reform was completed on September 13-20, 1993. A total of 399 farm owners/operators in the U.S. were surveyed.

The survey was designed to gather farm owners/operators opinions about the current state of health care, and about some of the proposed health care reforms that are currently being discussed. The survey was completed just prior to President Clinton's address to the nation on health care reform.

Significant findings of the survey are as follows:

- Farm owners/operators believe that "Doctor and hospital fees" and "The cost of treating those with no health insurance" are the two biggest contributors to increasing health care costs.
- Farm owners/operators believe it is very important that they maintain control over the choice of doctor and the choice of where they go for health care. Nearly six in ten said they would be unwilling to give up some control over those choices in exchange for lower costs. Less than one-quarter of survey respondents said they would be willing to give up some control to save money. About one in ten might be willing to give up control, depending on the amount saved.
- About three in ten farm owners/operators would be willing to have their taxes increased in order to help pay for health insurance coverage for all Americans. Another one in seven might be willing depending on the size of the tax increase. However, just less than one-half of farm owners/operators say they are unwilling to have their taxes increased to help pay for coverage for all Americans.
- About two-thirds of farm owners/operators believe that the government should not require all employers to pay for health insurance for full-time and part-time workers.
- Nearly six in ten farm owners/operators believe that a mix of government and the private sector can best administer cost efficient, quality health care. Only one in 50 think government alone can do the best job; about one in three think the private sector alone can do the best job.
- The two biggest priorities in reforming the health care system should be "Guaranteed insurance that cannot be cancelled" and "Reforming the medical malpractice system" according to farm owners/operators.
- About one-half of farm owners/operators are in favor of an IRA-type of health care account. Such an account would set money aside to be used only for medical costs, and would trade lower premiums for higher out-of-pocket costs.
- There were significant differences in opinion between those who said they voted for President Clinton in '92, those who said they voted for President Bush, and those who said they voted for Ross Perot.
- About sixty percent of survey respondents were women. The survey asked for "The person in your household that makes the majority of health care decisions for your household."
- Ninety-three percent of farm owners/operators in the survey have health insurance.

Further information about the survey itself and further analysis of responses to each of the questions can be found in the body of the report which follows.

A national telephone survey about health care reform was completed on September 13-20, 1993, among 399 farm owners/operators in the U.S.

The survey was commissioned by Communicating for Agriculture. CA is a non-profit, non-partisan rural organization made up of farmers, ranchers and rural small agribusiness owners and workers throughout the country. CA represents more than 80,000 people in family and individual members in 49 states. CA works actively on several public policy issues, including rural health care, developing new industrial uses of agricultural products, establishing beginning farmer finance programs, tax policy for producers and the self-employed, and rural development.

The survey was designed and completed by Minnesota Survey Research, St. Cloud, Minnesota. MSR is a national polling and research firm. MSR has been in business since 1978 and is a division of Meyer Associates, Inc. The parent company operates advertising, marketing, telemarketing and fundraising divisions for numerous regional and national clients.

Survey Respondents

The farmers chosen for this study all own and operate their own farm of at least 300 acres. Their names were selected at random from a database of over 1 million farm owners/operators provided by Ag/Response. Ag/Response is the list and marketing services division of *Progressive Farmer*, one of the country's widest circulation general farm magazines. Farmers in 39 of the continental 48 states were represented in the survey.

Further information about survey respondents appears at the end of this report.

Survey Design And Implementation

The survey questions were designed by Communicating for Agriculture and

Minnesota Survey Research. The questions covered two basic areas—the first asked for basic attitudes and beliefs about U.S. health care; the second asked for opinions about specific proposals for health care reform that have recently been discussed in the media.

Phoning took place from September 13-20, 1993. A total of 1,785 dials were made, and 590 farm owners/operators were contacted. 399 of these agreed to complete the survey. This is a completion rate of 68%.

The total of 399 respondents gives the survey data a margin of error of 3.9% at a 95% confidence level.

Interpreting The Results

When interpreting the results of this survey, there are two things that should be kept in mind. First, the survey introduction asked for "The person in the household that makes the majority of health care decisions for the family." This resulted in a female to male ratio of 60% female to 40% male.

Second, this survey was completed just prior to President Clinton's nationally televised September 22 health care speech before Congress. Many elements of his health care reform package were known and discussed prior to the speech. Some of those elements were questions in this survey.

This Report

In this report, the survey results concerning health care are given first. Next, a section describing the demographics of survey respondents is given. In the appendix, the survey questionnaire and a listing of the "Other" responses that were written down during phone calling are included.

The raw data for the survey, along with the three cross-tabulations that were run, are under separate cover.

Reasons For Health Care Costs
Questions 5-12

How much has each of the following contributed to the increased cost of health care?

	Very Significant	Somewhat Significant	Not Significant
Doctor and hospital fees	64.7%	27.1%	2.8%
Cost of treating those with no health insurance	61.4%	26.1%	6.8%
Unnecessary tests, X-rays and procedures	50.6%	34.3%	8.5%
Administrative expenses in the insurance industry	45.4%	35.1%	4.5%
Cost of prescription drugs	44.9%	41.6%	9.3%
New medical technology	40.6%	45.6%	8.3%
Government regulations	37.1%	33.8%	10.3%

Table 1—Questions 5-11

Questions 5-11. I'm going to read you several reasons that may be responsible for the increase in health care costs. For each, please tell me how much you think it has contributed to the increased cost of health care. The first choice is _____. Has that contributed significantly, somewhat significantly or not at all to the increase in cost? (Choices were: administrative expenses in the insurance industry, government regulation, new technology, unnecessary tests, X-rays and procedures, the cost of treating those with no insurance, and the cost of prescription drugs.)

Question 12. Of those you said were significant, (READ LIST), which one do you believe is the most significant reason for increasing costs?

Participants were asked to respond to each of the seven reasons listed in the question, and to rate each as "very significant," "somewhat significant," or "not significant." After they had completed that task, they were asked to go back and choose the single most important reason. There was general agreement between these two methods of asking this question (compare the pie chart of question 12 on the next page with the table of questions 5-11 above).

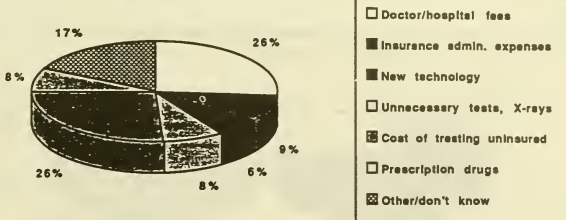
"Doctor and hospital costs" leads the list of reasons why medical costs are increasing, say survey respondents. Nearly two-thirds of them reported that these costs are a "very significant" reason.

Next in the list of reasons is "the cost of treating those with no health insurance." Again, nearly two-thirds of survey respondents pointed to this reason.

About one-half of survey respondents say that "unnecessary tests, X-rays and procedures" are very significant reasons.

Lowest on the list of very significant reasons is "government regulation." Only about one-third of survey respondents think it is a very significant reason for increasing health care

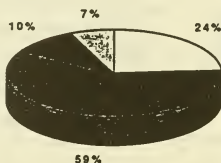
What is the most significant reason for increasing costs?



costs. However, this response and one other ("administrative expenses in the insurance industry") had very high "Don't know" percentages (18.8% and 15.0% respectively).

There were some differences in these questions based on who respondents voted for in 1992. For example, those who voted for Bill Clinton were somewhat less likely to believe government regulation is a very significant factor in rising health care costs than those who voted for George Bush or Ross Perot.

Would you be willing to give up some control over health care decisions in exchange for lower costs?



- ☐ Yes, give up some control
- ☒ No, want control
- ☒ Maybe, depends on savings
- ☐ Other/don't know

Question 13. Would you be willing to give up some control over your personal health care decisions—such as choice of doctor or where to go for care—in exchange for lower costs?

Only about one-quarter of survey respondents say they are willing to give up control over their health care decisions in exchange for lower costs.

About one in ten may be willing to give up some control, depending on the savings such a change would generate.

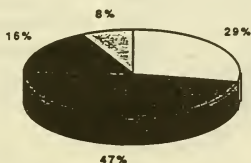
Overall, about 6 in 10 of those surveyed would not be willing to give up control of health care decisions to lower costs.

Presidential choice had some bearing on results in this question. Those who voted for Clinton in '92 were somewhat more likely to be willing to give up some control in exchange for lower costs than those who voted for Bush. Those who voted for Perot in '92 were even more likely to be willing to give up some control than Clinton supporters.

Willingness For Tax Increase

Questions 14-15

Would you be willing to have your taxes increased in order to help pay for coverage for all Americans?



- ☐ Yes, willing to have increase
- ☒ No, no increase
- ☒ Depends on size of increase
- ☐ Other/don't know

Question 14. The Clinton administration is considering health care reform that is designed to cover every American. This may result in new taxes for everyone. Would you be willing to have your taxes increased to insure coverage for every American? (If answered "Yes" or "Depends," respondents were then asked the next question.)

Question 15. How much would you be willing to have your taxes increased per year in order to help pay for coverage of all Americans?

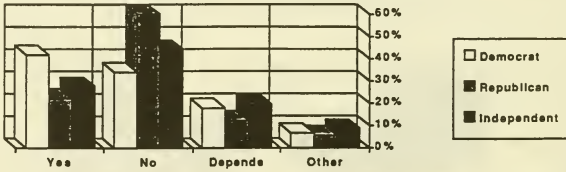
Just over one-quarter of survey respondents say they are willing to have their taxes increased in order to insure that every American has health insurance.

About one in seven report they may be willing, but it will depend on how much their taxes increase. Nearly one-half of those surveyed are not willing to have their taxes increased to insure coverage of all.

This was one of a few questions in the survey showing a significant difference between political parties. About four in ten respondents who identified themselves as Democrats would be willing to have their taxes increased to insure coverage for everyone. Only about one in five Republicans said they would be willing to see such an increase. (See chart on next page.)

This question also points out a sharp philosophical difference between those who voted for Clinton in '92 and those who voted for Bush. Almost one-half of those who voted for Clinton are willing to have higher taxes in order to provide coverage for all. Less than

Would you be willing to have your taxes increased to insure coverage for every American?



How much would you be willing to have your taxes increased per year in order to help pay for coverage of all Americans? (179 responses)

Less than \$50	27.4%
\$50 to \$99	25.1%
\$100 to \$249	23.5%
\$250 to \$500	6.1%
More than \$500	2.8%
Don't know	15.1%

Table 2—Question 15

one in five who voted for Bush are willing to see a tax increase.

Those who are willing, or might be willing, to see a tax increase were then asked how big an increase they could live with. More than three-quarters said that the increase should be \$249 or less per year. (See Table 2 above.)

Should the government require all employers, regardless of size, to pay for health insurance for full-time and part-time employees?



- ☐ Yes, should require
- ☒ No, should not require
- ☒ Full-time, but not part-time
- ☐ Other/don't know

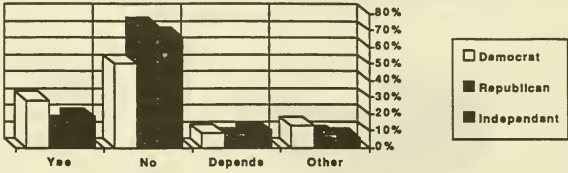
Question 16. Do you think the government should require all employers, regardless of their business size, to pay for health insurance for their full-time and part-time employees and workers?

Almost two-thirds of survey respondents answered "No" to this question. This is the largest negative response in this series of questions about health care plan proposals.

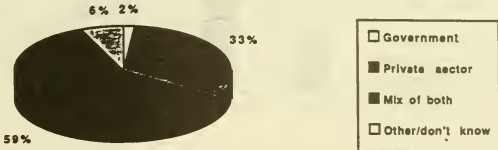
About one in five say that government should require insurance for all employees. A small group (about 3% of the survey respondents) feels that coverage should be mandatory for full-time employees, but not part-time, and another small group (5%) adds other qualifiers.

Democrats and Republicans are somewhat at odds over this issue. About twice as many Democrats as Republicans say that government should make coverage of all workers mandatory. And while one-half of Democrats are against mandatory coverage, three-quarters of Republicans are opposed. (See chart on next page.)

Should the government require all employers, regardless of size, to pay for health insurance for full-time and part-time workers?



Who can administer the most cost efficient, quality health care plan—the government, the private sector, or a mix of both?



Question 17. In your opinion, who do you feel can best administer the most cost efficient, quality health care—the government, the private sector, or a mix of both?

Nearly six in ten respondents say that a mix of government and the private sector is the best way to insure a cost-efficient, quality health care system.

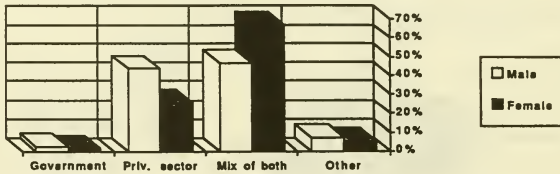
Few survey respondents believe that government alone can administer a cost efficient, quality health care system. Only eight respondents (2% of the total survey) feel government can do the best job.

On the other hand, about one-third of respondents believe that the private sector can do the best job of administering health care.

This question also elicited one of the few differences in response by gender. In the survey, men were more likely to say that the private sector can do the best job; women were more likely to say that a mix of government and the private sector is best. (See chart on next page.)

Responses to this question also varied by presidential voting pattern in '92. Clinton supporters say that a mix of government and private enterprise is better by a margin of almost five to one. Bush supporters split down

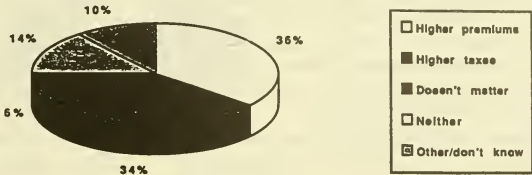
Who can administer the most cost efficient quality health care—the government, the private sector or a mix of both?



the middle, with one-half saying the private sector can do a better job, and one-half saying a mix is best. Perot supporters fell somewhere in the middle—about twice as many say a mix can do the best job as say the private sector alone is best.

Premiums Versus Taxes
Question 18

Which is preferable to you—higher health care premiums or higher taxes?



Question 18. Health care reform that improves access to care and increases the number of insured Americans may result in an increase in your health care costs. If you had to choose one, which of these options is preferable to you—higher premiums or higher taxes?

There was no clear consensus on this issue. Slightly more than one-third of respondents say that higher premiums are preferable; just about one-third say that higher taxes are preferable. And one in twenty respondents says it "Doesn't matter—it's all the same."

A significant minority (about one in seven respondents) says that neither is acceptable. This question also elicited a high "Don't know" response—nearly one in ten respondents had no opinion.

Those who voted for Clinton in '92 are somewhat more likely to report a tax increase was preferable; those who supported Bush are a little more likely to say higher premiums are best.

Priorities In Health Care Reform
Questions 19-24

How Important are each of these issues related to health care reform?			
	Very Important	Somewhat Important	Not Important
Having the guarantee that your insurance cannot be cancelled if you change jobs, become ill, or use health care services often	82.0%	10.5%	4.8%
Reforming the medical malpractice system by limiting lawsuit awards and insurance costs to help reduce doctor fees?	73.7%	18.8%	3.3%
Being able to deduct all of your premium costs from your federal income taxes	60.7%	27.6%	9.5%
Having a choice of different health plans and providers	53.4%	37.1%	6.8%
Lowering your current out-of-pocket medical expenses	50.1%	36.8%	9.8%

Table 3—Questions 19-24

Questions 19 - 23. I'm going to read you five issues for reforming our health care system. For each, please tell me how important these issues are to you. The first one is _____. Is that very important, somewhat important or not important? (Issues are listed in chart above.)

Question 24. Of those that you said were very important (READ LIST), which one do you think is most important?

More than four out of five survey respondents say that having guaranteed insurance—no matter if you change jobs, get sick, or use medical services often—is a very important element in health care reform.

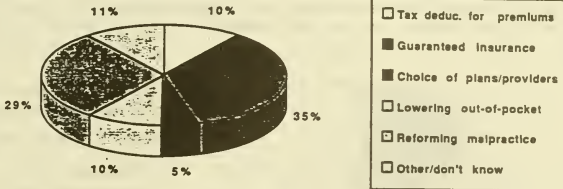
Next highest—with nearly three-quarters of respondents saying it is very important—is reforming the medical malpractice system to lower doctors' fees.

Lowest of the five listed issues was "Lowering your current out-of-pocket medical expenses," but still more than one-half of respondents said that was very important.

The chart on the next page shows the result when respondents were asked to name the single most important element. The table above shows the responses to each of the five elements.

There was one difference between men and women in response to this series of questions. Women are more likely to say that having a choice of health plans and providers is very important (60.2%) than are men (43.6%).

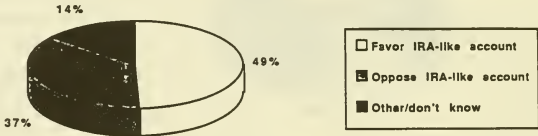
What is the most important element in reforming our health care system?



Those who voted for Clinton or Perot in '92 give "Guaranteeing that your insurance cannot be cancelled" as their first choice among these priorities. Those who voted for Bush list "Reforming malpractice" as their top priority. Those who voted for Perot are somewhat more likely to rate "Full deduction for medical insurance payments on income taxes" as most important than those who voted for either Bush or Clinton.

IRA-Type Health Care Account
Question 25

Do you favor an IRA-type program that would offer lower premiums, but higher out-of-pocket costs for routine medical expenses?



Question 25. There have been several health care reform ideas that have been suggested. One of these ideas is a plan that allows you to put a portion of the money you now spend on health insurance into a savings account like an IRA. This money would be tax-free but could be used only for medical expenses. Your insurance premiums would be lower, but it would require you to pay out of your pocket for routine medical expenses. Would you favor or oppose this plan?

About one-half of respondents say they like the idea of an IRA-type account. Just more than one-third oppose the idea.

More than one in ten report they "Don't know."

Questions 1-4, 26-28. Demographic questions including health insurance status, who provides coverage, number of family members covered under plan, political affiliation, presidential choice in 1992, and gender.

Selected Demographics of Respondents Questions 1-4 & 26-28

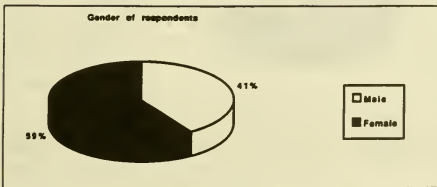
More than nine in ten farm owners/operators in this survey have health insurance, as shown in the chart on the next page. Of the 6% that don't have insurance, three-quarters say it is because insurance is too expensive.

Almost one-half of the survey respondents have their own individual insurance plan. About one-quarter have a plan through an employer of one of the family members. Although only 7% reported they have an "Association plan," industry figures show a much higher percentage. It is believed that many of the plans reported as "Individual" probably are some type of association plan.

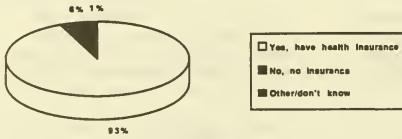
A majority of the survey respondents have one or two family members covered under their plan. The median response for this question is in the "two family members covered" category. About one in seven of the survey respondents are covered by Medicare. Less than one in ten have an association plan.

More than one-third of survey respondents report they are "Independent" when asked their political affiliation. Slightly more than one-quarter say they are Democrats, and just more than one-third report they are Republicans. In the 1992 election, about three in ten voted for Bill Clinton and just more than one-third voted for George Bush. About one in seven voted for Ross Perot.

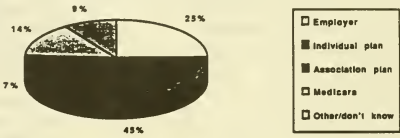
Six in ten of the survey respondents were women. The screening question used to select survey participants asked for "The person that makes the majority of health care decisions for the household." The percentage of women is about the same as in other surveys in which the same screening question was used.



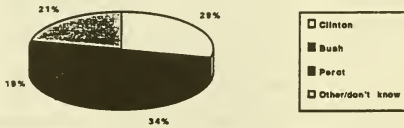
Do you currently have health insurance?



Who do you receive your health insurance coverage from?



Presidential choice of respondents in '92



Political affiliation of respondents



Chairman STARK. Dr. Ehrenkranz.

STATEMENT OF RICHARD A. EHRENKRANZ, M.D., PUBLIC POLICY FELLOW, OFFICE OF GOVERNMENT AFFAIRS, MARCH OF DIMES BIRTH DEFECTS FOUNDATION

Dr. EHRENKRANZ. Mr. Chairman, members of the subcommittee, I am Dr. Richard Ehrenkranz. I am pleased to appear before you today on behalf of the March of Dimes Birth Defects Foundation.

Currently, I am a March of Dimes public policy fellow, while on sabbatical leave from Yale University School of Medicine, where I am a professor of pediatrics, obstetrics and gynecology, and practice at the Children's Hospital at Yale-New Haven Hospital as clinical director of the Newborn Special Care Unit.

The 100 chapters and 1 million volunteers of the March of Dimes share your concern about the growing number of uninsured Americans and the increasing cost of health care. We commend you for your long commitment to improve the U.S. health care system and hope that your deliberations will lead to a speedy enactment of health care reform.

The mission of the March of Dimes is to improve the health of babies by preventing birth defects and infant mortality. Thus, we have a special interest in barriers to health care faced by millions of American families who want to have healthy babies. We want these families to have health security. It must be recognized that any major changes in the health care system will have an impact on the health of the 4 million babies born each year.

Health insurance is the first critical step to ensuring access to care. As the number of uninsured has grown in recent years, women of childbearing age and children were among the most likely to lose coverage. Even among those who were insured, preventive services such as prenatal care and immunization are often left out of private employer-based plans.

Experts tell us of the importance of quality maternity care that begins with early prenatal care, but the Nation has made no progress in this area since 1979. Each year, one-quarter of all pregnant women receive no prenatal care in the critical first 3 months of pregnancy.

In addition, many of the sickest populations have been left behind. For example, birth defects are often considered, "preexisting conditions," and infants are then excluded from insurance plans. If health reform is not enacted, these children could be outside of the system for their entire lives.

In my clinical practice as a neonatologist, I have cared for many high-risk babies and know that appropriate care, both prenatal and/or neonatal, delivered in a timely fashion can make the difference between life and death or prevent a lifetime of disability.

The Nation can afford a better system of care for mothers and babies. The results of a recent study sponsored by the March of Dimes and conducted by RAND found that we spend \$27.8 billion each year, less than 5 percent of total health care dollars, to finance maternity and infant care. However, a large portion of these costs are for the care of sick babies. Refocusing our spending on prevention will reduce health care costs and infant mortality. Uncompensated care costs—and the government payments to offset

them—total \$2.4 billion annually. With universal coverage, both patients and providers would be better off. Families would have increased access to care, and providers would be assured payment.

The March of Dimes does not endorse any one approach to health care reform. We believe that any health care reform proposal should: One, provide affordable and user-friendly health care coverage for all pregnant women and infants; two, define a basic set of benefits for pregnant women and children with emphasis on prenatal care and other preventive services; three, improve the supply and distribution of maternity and pediatric providers; and, four, contain mechanisms to coordinate funding streams, contain costs, and assure quality to protect the health of mothers and infants.

You have asked us to share our views on the Clinton health reform plan. In many respects, the American Health Security Act fits our criteria for effective reform. We are particularly pleased that it provides coverage for the 9 million uninsured women of child-bearing age. At the same time, we have some concerns.

First, while the proposed standard benefits package will be adequate for the vast majority of pregnant women and infants, we are concerned that all children with birth defects will not be covered for the services they need.

Special services, such as physical therapy, are covered as postacute care following "illness" or "injury." Birth defects do not necessarily fall into either category. Therefore, the March of Dimes urges that birth defects would be—should be explicitly included.

Service limitations for children with birth defects and other special health care needs are also of concern. For example, durable medical equipment, including prosthetic and orthotic devices, is limited, with no customized devices being included. Adapted or customized wheelchairs, communication devices, and prosthetics are particularly important to children whose bodies are rapidly growing and changing. Therefore the March of Dimes urges you to ensure that customized equipment will be covered for children.

Briefly, other recommendations by the March of Dimes for improving the Clinton health care reform proposal include: One, assuring financing and low-cost sharing for all maternity costs including labor and delivery; two, mandate health education, including smoking cessation, as a component of pregnancy-related services; three, fully integrate Medicaid recipients into mainstream coverage; four, include prenatal services for undocumented pregnant women so as to improve the health of babies who would be born citizens; five, include a process to rapidly disseminate new proven and cost-effective perinatal health interventions; and, six, provide adequate funding for the Public Health Service access initiatives.

In conclusion, we understand that there are no easy answers to the current crisis in health care. At the same time, we urge you to act thoughtfully and expeditiously to ensure affordable, available, and appropriate health care for all Americans. Our Nation cannot have the world's healthiest babies until our health care system provides access for every woman and baby.

Thank you.

Chairman STARK. Thank you.

[The prepared statement follows:]

TESTIMONY OF MARCH OF DIMES BIRTH DEFECTS FOUNDATION BEFORE
THE U.S. HOUSE OF REPRESENTATIVES, WAYS AND MEANS COMMITTEE,
SUBCOMMITTEE ON HEALTH

Presented by Richard A. Ehrenkranz, M.D.
Public Policy Fellow
Office of Government Affairs
March of Dimes Birth Defects Foundation

Professor of Pediatrics and Obstetrics and Gynecology
Yale University School of Medicine and
Clinical Director of the Newborn Special Care Unit
Children's Hospital at Yale-New Haven
New Haven, Connecticut

October 21, 1993

My name is Dr. Richard Ehrenkranz. On behalf of the March of Dimes Birth Defects Foundation, I am pleased to appear before you as a long time volunteer and former research grantee. Currently, I am a March of Dimes public policy fellow while on sabbatical leave from Yale University School of Medicine, where I am a Professor of Pediatrics and Obstetrics and Gynecology and practice at the Children's Hospital at Yale-New Haven Hospital as Clinical Director of the Newborn Special Care Unit.

The March of Dimes, embodied by 100 chapters and one million volunteers, shares the concern about the growing number of uninsured Americans and the increasing cost of health care being expressed by other voluntary health organizations and professionals, as well as business, labor, and elected leaders. We commend you for your long commitment to improving the U.S. health care system and hope that your deliberations will lead to speedy enactment of health care reform.

The mission of the March of Dimes is to improve the health of babies by preventing birth defects and infant mortality. Thus, we have a special interest in the barriers to health care faced by millions of American families who want to have healthy babies. We want these families to have health security. It must be recognized that any major changes in the health care financing system will have an impact on the health of the 4 million babies born each year.

WHAT IS THE PROBLEM?

Experts tell us of the importance of quality maternity care, that begins with prenatal care in the first three months of pregnancy, but the nation has failed to heed the call to ensure access for all women.

- o The nation has made no progress in improving early prenatal care use since 1979. Each year one-quarter of all pregnant women receive no prenatal care in the critical first three months of pregnancy, and more than 90,000 babies are born without benefit of any prenatal care visits -- this means that their mothers did not see a health provider before arriving at the hospital to give birth.

Insurance is the first critical step in assuring access to services. As the number of uninsured has grown in recent years, women of childbearing age and children were among those most likely to loose coverage.

- o Despite recent expansions of Medicaid, 400,000 pregnant women have no health insurance, public or private. ¹
- o Nearly 9 million women of childbearing age (18-44 years) have no health insurance -- this figure includes 6 million women who work. ²

Even among the insured, preventive services such as prenatal care and

immunization are often left out of private, employer-based benefit packages.

- o An estimated 5 million women have private health insurance which does not cover the complete maternity package, including both prenatal and birth services.³
- o Half of private, employer-based indemnity plans do not provide coverage for immunization services.⁴

Many of the sickest populations have been left behind. For example, because birth defects are often considered "pre-existing conditions," infants are then excluded from insurance plans. For those infants with major birth defects who survive, coverage may not be available for care that could prevent or limit disabilities. If no health reform plan is enacted, these children could be outside of the health insurance system for their entire lives. In my clinical practice as a neonatologist, I have cared for many high risk babies and know that appropriate care --both prenatal and/or neonatal-- delivered in a timely fashion can make the difference between life and death or prevent a lifetime of disability.

WHAT DOES THE NATION SPEND ON MATERNITY AND INFANT CARE?

The results of a recent study⁵ (sponsored by the March of Dimes and conducted by RAND) underscore the impact of health care financing on access to maternity and infant care. RAND found that:

- o Only a small percentage of total health costs are spent on maternity and infant care -- \$27.8 billion or less than 5% of total health care spending. Much of today's costs are for care of sick babies. Refocusing our health spending on prevention will reduce health care costs and infant mortality.
- o Uncompensated care costs -- and the government payments to offset them -- were \$2.4 billion in 1989, mainly for deliveries and care of sick newborns. With universal coverage, both patients and providers would be better off -- women would have increased access to care and providers would be assured payment.
- o Families pay over \$3 billion out-of-pocket for maternity and infant care each year. That \$3 billion is the families' share of care for pregnant women and their 4 million babies. This is an enormous burden, particularly since most families having babies are young and have low or moderate incomes.

WHAT MUST BE DONE?

The March of Dimes has endorsed no one approach to health care reform. We recognize that improving our complex health care system will, of necessity, include a range of strategies to address the barriers and high costs we face today.

The March of Dimes Birth Defects Foundation has a special interest in access barriers faced by millions of American families who want to have healthy babies. The March of Dimes believes that a health care reform proposal should: 1) provide affordable and user-friendly health care coverage for all pregnant women and infants; 2) define a basic set of benefits for pregnant women and children, with emphasis on prenatal care and other preventive services; 3) improve the supply and distribution of maternity and pediatric providers; and 4) contain mechanisms to coordinate funding streams, contain costs, and assure quality to protect the health of mothers and infants.

VIEWS ON THE CLINTON HEALTH REFORM PLAN

You have asked us to share our views on the Clinton health reform plan. In many respects, the American Health Security Act fits our criteria for effective reform. We are particularly pleased that it provides coverage for the 9 million uninsured women of childbearing age. At the same time, we have some concerns about how the plan will protect the health of babies.

Benefits: Based on the descriptions we have seen to date, the basic benefits package will be adequate for the vast majority of pregnant women and infants. However, we have two concerns: 1) Will all children with birth defects qualify for the specialized services they need? and 2) Given that health education is optional, will health plans consistently provide these needed services for pregnant women?

- o Special services (such as outpatient rehabilitation, extended care, or home health) are covered as post-acute care following "illness or injury." Birth defects (congenital conditions) do not necessarily fall into either category. The March of Dimes urges inclusion of language that would specifically include birth defects.
- o Service limitations for children with birth defects and other special health care needs also are of concern. For example, durable medical equipment (including prosthetic and orthotic devices) are limited -- with no customized devices being included. Adapted or customized wheelchairs, communication devices, and prosthetics are particularly important to children whose bodies are rapidly growing and changing. The March of Dimes urges inclusion of language that would ensure that customized durable medical equipment would be provided to children with specialized needs.
- o Health education in the form of nutritional counseling and, for those who need it, smoking cessation are critical preventive services during pregnancy. For example, an estimated 25% of low birthweight could be prevented with cost-effective smoking cessation programs. Yet the proposal permits, but does not mandate, health plans to offer such courses. The March of Dimes believes that health education, including smoking cessation, should be a mandatory component of pregnancy-related services.

Cost sharing: The overall approach to cost sharing seems fair to Americans covered under the comprehensive benefit package. However, we remain concerned that while prenatal care will be exempt from cost-sharing, there may be co-payments and deductibles related to delivery and birth. While low cost-sharing plans will have no co-payments for inpatient services, it is not clear that all pregnant woman will have the option to be enrolled in such a plan. This question needs attention, particularly since obstetric and newborn costs were a key contributor to uncompensated care in the 1980s.

- o Services at the time of birth accounted for an estimated 25% of uncompensated care in the mid-1980s. Medicaid coverage for low income pregnant women alleviated some of this burden, and states' uncompensated care pools offset these costs in other cases.
- o Yet even by 1989, uncompensated care for maternity and infant care (and government mechanisms to offset them) totaled \$2.4 billion -- with delivery and neonatal care accounting for \$1.9 billion of this amount. ⁶

The March of Dimes believes that health care reform should assure financing for all maternity costs, including labor and delivery.

Medicaid: In recent months, the March of Dimes and other groups worked with you to guarantee that women and children in the Medicaid program would be "integrated" into mainstream care under the Clinton plan. You have provided some assurances that there would be no lesser payments and discrimination related to Medicaid. However, we remain concerned that the proposed approach may leave an incentive to remain on welfare rather than go to work. The March of Dimes urges full integration of the Medicaid population.

Undocumented pregnant women : The Clinton Administration has decided that undocumented persons will not be entitled to a health security card -- this is a particular problem with undocumented pregnant women whose infants will be U.S. citizens. It is not clear whether their employers will be prohibited from contributing or from voluntarily purchasing coverage for undocumented workers. It is a positive step that current

protections for emergency services -- including delivery and birth -- would continue in Federal law. The March of Dimes urges inclusion of prenatal services for undocumented pregnant women to improve the health of babies who would be born citizens and have health security protections.

Dissemination of new knowledge: New medical technology (such as neonatal medicine, fetal therapy, and gene therapy) has saved the lives of millions of babies, with most growing to be healthy and contributing citizens. We are pleased that the Clinton Health Plan includes emphasis on health research in perinatal health and birth defects. The promulgation of information about best practices and effective treatment is equally important to improving health outcomes. We are concerned that the National Quality Management Program may: focus only on cost-quality tradeoffs; may delay dissemination of effective new interventions with bureaucratic process; or spend too little time on perinatal and birth defects issues. The latter is of particular concern since adult chronic disease research and prevention currently have dominance. The March of Dimes recommends a process to rapidly disseminate newly proven and cost-effective perinatal interventions.

Public health and essential providers: The concept of a Public Health Service Access Initiative is a very positive and forward looking approach. Accessible health care must be affordable, available, and appropriate -- thus, coverage alone will not guarantee access. We are pleased that the Clinton plan focuses on school health, the National Health Service Corps, capacity expansion, and core public health functions (e.g. data and surveillance, infectious disease control). We understand that the Clinton plan would give states the resources and flexibility to design their own approach to "enabling services" (e.g. outreach, case management). The March of Dimes is concerned that a block grant strategy could undercut current community-based efforts to reach families and children at social and medical risk.

CONCLUSION

We understand that there are no easy answers to the current crisis in health care. However, when we fail to ensure access to care for pregnant women and children, we miss opportunities to prevent costly health problems. When families delay preventive care, society pays.

- o Prenatal care has been found to be effective and cost effective -- saving \$3 for every \$1 invested by improving infant health and reducing neonatal intensive care costs.
- o Smoking cessation programs for pregnant women can save \$6 for every \$1 invested -- doubling the savings of prenatal care. Smoking during pregnancy nearly doubles the risk of having a baby born too small, and mothers who smoke account for 28% of low-birthweight births.

We urge policy-makers to act thoughtfully and expeditiously to ensure affordable, available and appropriate health care for all Americans. The nation cannot afford to delay health care reform. Every day 11,000 babies are born, 800 have low birthweight, 410 have a birth defect, and over 100 die.⁷ Most American women experience pregnancy during their lives, with nearly 7 percent of women of childbearing age giving birth each year. Our nation cannot have the world's healthiest babies until our health care system provides access for every woman and baby.

REFERENCES

1. National Commission on Children. *Beyond Rhetoric: A new American agenda for children and families*. Washington, DC, 1991.
2. Snider, S. *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1992 Current Population Survey*. Employee Benefit Research Institute, Washington, DC, 1993.
3. Gold RB, Kenney AM, and Singh S. *Blessed Events and the Bottom Line: Financing maternity care in the United States*. Alan Guttmacher Institute, New York, NY, 1987.
4. National Vaccine Advisory Committee. *Access to Childhood Immunization Services*. U.S. Public Health Service, Washington, DC, 1992.
5. Long SH, Marquis MS, Harrison E. "The Financing of Perinatal Care." In Press, RAND, Washington, DC, 1993.
6. RAND, Op Cit.
7. Petrini, J, Damus K, et. al. *StatBook: Statistics for Healthier Mothers and Babies*. March of Dimes Birth Defects Foundation, White Plains, NY. 1993.

Chairman STARK. Mr. Bross.

**STATEMENT OF DANIEL T. BROSS, EXECUTIVE DIRECTOR,
AIDS ACTION COUNCIL**

Mr. BROSS. Mr. Chairman, thank you for giving the AIDS Action Council this opportunity to contribute to this important hearing on consumer perspectives on President Clinton's national health care reform proposal.

AIDS Action Council serves as the Washington representative of over 1,000 community-based organizations providing services to people living with AIDS and HIV.

AIDS Action Council is devoted exclusively to advocacy for effective national AIDS and HIV policy.

Over 1 million Americans are currently living with HIV infection. More than 194,000 Americans have died. We will never know how many of those individuals died prematurely or experienced unnecessary suffering because of the system's failure to provide appropriate medical management of HIV disease.

A dramatic overhaul of our current health care delivery system is an imperative for people living with HIV and AIDS in this country and for an effective national response to the AIDS epidemic.

People living with AIDS are poorly served by the current system. Forty percent of people with AIDS are Medicaid recipients, and at least 30 percent are uninsured. Even for those who are insured, discrimination by insurers, caps on overall care for AIDS treatment, preexisting condition exclusions, and a range of other common practices make health care for Americans living with AIDS a frustrating, financially debilitating, and sometimes life-threatening experience.

Some have argued that the AIDS epidemic has presented our current health care system with its greatest challenge. If that is so, then the current health care predicament for people living with AIDS and the broad-based public outcry for national reform offer a ringing indictment of the system's inability to meet that challenge.

The American Health Security Act of 1993 would make health care a right, rather than a privilege, for every American. It is responsive to many of the problems people with AIDS currently face in the delivery of their health care—preexisting condition exclusions, disease specific caps, and experience rating.

The Clinton plan calls for a comprehensive benefit package, and the nature of HIV disease requires access to a full range of health care services to ensure quality of care.

AIDS Action Council is committed to effectively representing the health care concerns of people living with AIDS during this national health care reform debate. In that regard, we offer strong support and will fight to preserve key elements of the Clinton plan which are critical to people living with AIDS, just as we will advocate for a number of essential improvements in the legislation when it finally reaches Capitol Hill.

Based on the elements of the American Health Security Act which have been released, we offer our strong support for a number of components of the administration's proposal, including: Universal coverage by 1997; prohibition against preexisting condition ex-

clusions, disease specific caps, and experience rating; the portability and comprehensiveness of the benefits package; limitations on copayments and out-of-pocket maximums; risk adjustment by disease and by socioeconomic status for payments to providers; limits on premium increases; employer mandate; and single-payer option for States.

From the perspective of the AIDS community, these elements and others described in our full statement are essential to the integrity of the Clinton plan and its promise of health security for all Americans.

Health security for people living with AIDS and HIV will only be realized if each plan is required through clear and enforceable provisions to provide the continuum of services needed for the proper medical management of HIV disease.

Looking at the proposal through the lens of the HIV epidemic, we do have concerns about some elements in the plan, seek clarity about others, but stand ready to work for essential improvements.

It is our firm belief that any national health care reform plan enacted by the Congress can be judged by its responsiveness to the health care needs of Americans living with HIV.

Let me briefly enumerate a number of AIDS Action Council's concerns regarding the Clinton plan:

Prescription drug coverage. It is essential that coverage include the so-called off-label use of drugs. Due in part to the limited number of standard treatments for HIV disease and its related opportunistic infections, people with HIV are often heavily dependent on the off-label use of medication.

OB/GYN services. We support OB/GYN services as part of the preventive health service package but argue for annual Pap smears for all women instead of the 3-year intervals currently recommended in the Clinton plan.

Substance abuse and mental health service treatment. While we applaud the inclusion of substance abuse treatment and mental health services in the basic benefit plan, the Clinton proposal falls far short of meeting the substance abuse treatment and mental health care needs of people living with AIDS and HIV. A 50 percent copayment for outpatient mental health and substance abuse services in addition to the \$1,500 out-of-pocket expenses and the premium copayments which most people with HIV will incur, could prove to be financially prohibitive.

And, finally, Mr. Chairman, we have grave concerns about the issues of confidentiality and antidiscrimination.

Since the beginning of the AIDS epidemic, people living with AIDS and HIV have faced discrimination in all aspects of their lives, from the workplace to their living place and even in their religious communities. The last place they should face discrimination is in the health care setting. But tragically, they have. Whether it is insurers or employers arbitrarily capping benefits or doctors, dentists, and hospitals refusing medical treatment, the American health care system not only fails to adequately care for people living with AIDS, it contributes to their premature death.

Thank you.

[The prepared statement follows:]

TESTIMONY OF DANIEL T. BROSS
EXECUTIVE DIRECTOR OF AIDS ACTION COUNCIL

Thank you for offering AIDS Action Council the opportunity to contribute to this important hearing on consumer perspectives on President Clinton's national health care reform proposal. AIDS Action Council serves as the Washington representative for over 1,000 community-based organizations providing services to people living with HIV/AIDS. AIDS Action Council is devoted exclusively to advocacy for effective national HIV/AIDS policy.

Over one million Americans are currently living with an AIDS diagnosis. More than 194,334 have died. We will never know how many of those individuals died prematurely or experienced unnecessary suffering because of the failure of our health care system to provide appropriate medical management of HIV disease. A dramatic overhaul of our current health care delivery system is an imperative for Americans living with HIV/AIDS and for an effective national response to the AIDS epidemic. People living with HIV/AIDS are poorly served by the current system. Forty percent of people with AIDS are Medicaid recipients and at least 30 percent are uninsured. Even for those who are insured, discrimination by insurers, caps on overall care for AIDS treatment, pre-existing condition exclusions and a range of other common practices make health care for Americans living with HIV/AIDS a frustrating, financially debilitating and sometimes, life-threatening experience. Some have argued that the AIDS epidemic has presented our current health care system with its greatest challenge. If that is so, then the current health care predicament of people living with HIV/AIDS and the broad-based public outcry for national reform offer a ringing indictment of the system's inability to meet that challenge.

The American Health Security Act of 1993 would make health care a right, rather than a privilege, for every American. The promise of the President's proposal is to provide all Americans with comprehensive, affordable and appropriate health care by 1997. It is responsive to many of the problems people with HIV/AIDS currently face in the delivery of their health care---pre-existing condition exclusions, disease-specific caps, experience rating. The Clinton plan calls for a comprehensive benefit package, and the nature of HIV disease requires access to a full range of health care services to ensure quality care.

AIDS Action Council is committed to effectively representing the health care concerns of people living with HIV/AIDS during this national health care reform debate. In that regard, we offer strong support and will fight to preserve key elements of the Clinton plan which are critical to people living with HIV/AIDS just as we will advocate for a number of essential improvements in the legislation when it reaches Capitol Hill.

Based on the elements of the American Health Security Act which have been released, we offer our strong support for the following components of the Administration's proposal:

- Universal coverage by 1997
- Prohibitions against pre-existing condition exclusions, disease-specific caps and experience rating
- Portability and comprehensiveness of benefit package - prescription drugs, ob-gyn services, home health care, hospice care, substance abuse treatment, mental health services, and prescription drug coverage for Medicare recipients are all crucial covered services for persons with HIV/AIDS.
- Subsidies for low-income persons
- Inclusion of Medicaid recipients with access to same benefits and providers as other Americans.
- Limitations on co-payments and out-of-pocket maximums
- Risk-adjustment by disease and by socioeconomic status for payments to providers
- Limits on premium increases.
- Preservation of Ryan White Care Act and other public health categorical programs which serve people with HIV/AIDS.
- Employer mandate
- Single payer option for states

From the perspective of the HIV community, these elements are essential to the integrity of the

Clinton plan and its promise of health security for all Americans. Health security for people living with HIV and AIDS will only be realized if each plan is required, through clear and enforceable provisions, to provide the continuum of services needed for the proper medical management of HIV disease.

Looking at the proposal through the lens of the HIV epidemic and those who live with HIV/AIDS as well as those who work to provide services to its victims in the community on the front lines, we have concerns about some elements in the plan, seek clarity about others, and stand ready to work for essential improvements. It is our firm belief, that any national health care reform plan enacted by the Congress can be judged by its responsiveness to the health care needs of Americans living with HIV/AIDS.

Let me briefly enumerate a number of AIDS Action Council's concerns with components of the American Health Security Act as it has been publicly outlined. We have already shared these concerns with Administration officials and are hopeful that clarity or changes will be forthcoming in a number of areas when the legislation is introduced.

Benefit Package

Prescription Drug Coverage. It is essential that coverage include the use of so-called "off-label" drugs. Due in part to the paucity of standard treatments for HIV disease and its related opportunistic infections, people with HIV are often heavily dependent on the use of "off-label" medications. We are also concerned that allowing individual health plans to establish drug formularies and drug utilization reviews will result in this benefit being overly circumscribed.

Ob-gyn services - We support Ob-gyn services as part of the preventive health service package and argue for annual pap smears for all women instead of the three year intervals currently recommended in the Clinton plan. HIV in women frequently manifests itself in gynecological complications which will be identified and treated more quickly with annual pap smear screenings.

Substance abuse treatment and mental health services . While we applaud the inclusion of substance abuse treatment and mental health services in the basic benefit plan, the Clinton proposal falls short of meeting the substance abuse treatment and mental health care needs of persons living with HIV/AIDS. People with HIV/AIDS frequently require both substance abuse treatment and mental health care. Further, a fifty percent co-payment for outpatient mental health and substance abuse services in addition to the \$1500 out-of-pocket expenses and premium co-payments which most people with HIV will incur, could prove to be financially prohibitive.

Home health care. We need clarity to ensure that the disability criteria for program participation includes individuals living with HIV/AIDS and that the copayment structure for this service is not a major barrier to participation.

Medicaid and Low-Income Populations

Medicaid. The Clinton proposal would ensure that Medicaid recipients who receive cash assistance will continue to receive wrap-around benefits, which are essential to enabling people to access health care. However, under the draft Clinton plan, medically needy Medicaid recipients, including a significant proportion of Medicaid recipients with HIV/AIDS would not. We believe that Medicaid recipients should not experience a loss of benefits under national health care reform. Wrap-around services and all benefits and services currently available to recipients under existing state waivers should be maintained.

Low-income. We believe that there should be caps on the percent of income that an individual can be required to pay for his or her premium, to ensure that low-income individuals are able to afford health care coverage. Caps on premiums, premium subsidies, and other mechanisms for ensuring affordable health care coverage should be available to all low-income persons, especially those with disabilities.

Anti-Discrimination/Confidentiality

Since the beginning of the AIDS epidemic, people living with HIV/AIDS have faced discrimination in all aspects of their lives, from the workplace to their living place and even in their religious communities. The last place they should face discrimination is the health care setting. But tragically they have. Whether it is insurers or employers arbitrarily capping benefits, or doctors, dentists and hospitals refusing medical treatment; the American health care

system not only fails to adequately care for people living with AIDS, it contributes to their premature deaths. The passage of the Americans with Disabilities Act was a significant moment for our community, bringing great hope that such discrimination would end. Just two weeks ago, the Department of Justice brought two cases charging dentists with violations of the ADA by refusing to care for people with HIV/AIDS. The setbacks people living with AIDS faced in the wake of the McGann decision and the uncertainty of how discrimination in health care benefits will be remedied under the ADA convince us that any efforts to reform the health care system in this country will fail if guarantees of anti-discrimination are not explicitly set out in the law and enforced in practice. As we noted previously, the incentives to deny health care coverage to Americans on the basis of their health condition, socio-economic status, race, or gender, particularly in managed care systems, will continue to exist, whether overtly or not, even if the essential elements we have spoken about today are included in health care reform. Therefore, it is imperative that Congress specifically provide anti-discrimination protections to assure that all Americans will have quick and meaningful recourse to remedy discrimination based on health care condition, socio-economic status, race or gender that prevents them from getting appropriate and affordable health care.

Americans must also be assured that their medical records will be kept confidential, and that the data collection plans for utilization reviews, report card preparation, and other purposes will utilize only blinded data. Without such confidentiality protections, it will be impossible to provide meaningful anti-discrimination protections for people.

Preservation of Vital Public Health Categorical Programs

The Administration's bold plan to integrate all Americans, including poor individuals and other traditionally underserved populations into the mainstream health care delivery system is a laudable, but untried goal. From the perspective of the HIV community, it is imperative that federal safety net programs, including the Ryan White Care Act, the substance abuse block grant, federal tuberculosis initiatives and federally-funded HIV prevention programs remain intact during the transition to national reform and until it can be clearly demonstrated that the health alliances can provide the services currently provided by these programs. Many of these programs provide services which will not be available through the health care system. Case management, and adult dental services are just two of the services currently provided under Ryan White which will not be available through health plans. The substance abuse block grant is the primary source of funding for long-term community based residential care for drug dependent persons, including women with dependent children. The substance abuse benefit simply will not provide that duration or intensity of care and it would be short-sighted to finance the substance abuse/mental health benefit with federal substance abuse block grant funds. AIDS Action will work to preserve and enhance funding for public health programs critical to the well-being of persons living with HIV/AIDS.

Conclusion

Despite the questions and cautions we have raised about the Clinton plan, we welcome the opportunity to support the Administration's effort to work for dramatic reform of the health care system. The stakes are very high and opposition to reform is formidable. The leadership of the forces opposing major change are familiar to the HIV community. From the insurance industry to the new unholy alliance between the Christian Coalition and the National Federation of Independent Businesses, the call for the status quo or for minor tinkering with the system comes from those who have profited from building barriers to health care and who have offered people with AIDS moral condemnation instead of vital health care services. The American Health Security Act moves the national health care reform debate to a new moral high ground by presenting comprehensive health care as a fundamental right of citizenship, regardless of race, gender, employment status, health or HIV status. It is our intention to do all we can to see that meaningful reform is enacted and that the special needs of Americans living with HIV and AIDS are heard and responded to in the upcoming debate.

Chairman STARK. Thank you.

Unfortunately, Dr. Ehrenkranz, you have just made a liar out of me. But maybe not all is not lost. I have, for I will bet you, 5 years been using an anecdote; and it appears that I just made it up. But sometimes those are the best kind to illustrate the conundrum we are in on this issue of costs, and saying to people it doesn't really make much difference what the President estimates the costs are going to be because, in the final analysis, we have to use the numbers that the Congressional Budget Office gives us. That is the law.

So even though we don't like CBO estimates—and I say one of the things that is difficult for people to understand, including myself, is that, and I have used this illustration, that for every dollar I spend in prenatal care, I am going to save \$5 in pediatric care over the next 5 years.

And, you know, nobody's ever stood up and challenged me until today. But nonetheless, what happens is the CBO says, we may agree with you, but we can't score you, as they say, for that \$5 of savings because there is no requirement in law that we spend it. And we can only get a savings if we reduce a spending that is mandated.

It sounds dumb, but Mr. Thomas and I have to both live by those rules, and sometimes it hurts his program, sometimes it hurts mine. But you, today, unfortunately, have said it is only \$3 in savings for every dollar. I will still take that as a muted endorsement. And now I will use the \$6 for every dollar if we get them to quit smoking. That is even more dramatic, and I will now quote you from now on to say how much we can save.

They still won't score me, but it is a much more draconian savings, and I thank you for that contribution to trying to get more preventive care involved.

As you have reviewed the President's plan, are you comfortable that pregnant women will get the kind of prenatal services you feel they need? Or is it not addressed at all?

What is your comfort level in that regard?

Dr. EHRENKRANZ. We are pleased with many of the aspects of the plan, specifically its universality, the portability.

We have some concerns that if the Medicaid population is not fully integrated into the plan, women and, therefore, children will lose services and benefits.

Chairman STARK. Not only not fully integrated, I mean they are going to eliminate Medicaid as an entitlement.

Now, how do they do that? They say, well, we will have entitlement for the poor and low-income, but it will be capped. So it is an entitlement until you hit the cap; and from then on, we have to go and get an appropriation.

And I want to tell you, getting an appropriation to help the poor and the indigent is a tough row to hoe in this institution.

Dr. EHRENKRANZ. In addition, I think we want to be careful that we are not maintaining a dual class system, where women are embarrassed or feel that they are looked down upon when going for and receiving care.

Chairman STARK. The President's plan is a hornbook on how to establish a dual-class system and build incentives into the dual-class system to increase the disproportion in the kind of coverage.

If you are going to write a way to impact the poor and help the rich get better care, you couldn't have done a better job than Ira Magaziner did for the President.

So there are a few minor corrections that we have to make.

Let me ask Mr. Smedsrud, you represent small business people in the rural community?

Mr. SMEDSRUD. Essentially farmers.

Chairman STARK. I had the pleasure of joining the head of the NFIB at a meeting recently. I think it was the white supremacist's annual convention, but other than that it was a meeting at which we discussed health care. I brought to his attention, which he hotly denied, but I have a copy, that in May 1992 the members of the NFIB were polled and they were asked, among other things, this question. Would you support having to provide health insurance to all employees even if you did not have to pay any of the cost?

OK. Would you support having to provide health insurance to all of your employees even if you did not have to pay any of the cost?

Sixty percent said no. Eleven percent were undecided. And there were 29 percent of those good folks who did the right thing, in my opinion, and said that would be OK.

Now, how do you suppose your members would come down on that same question?

Mr. SMEDSRUD. Our members would probably—most of our members don't have very many employees, if they have employees at all, one or two.

Most of those—

Chairman STARK. And they might be family members.

Mr. SMEDSRUD. And they may be family members.

We did the survey of farmers, which is attached to my statement. About two-thirds of those responding said they would not be willing to pay for a mandate.

They were told, I think, that the cost of a mandate was 8 to 10 percent. We did this before the 7.9 percent or the 3.5 percent became public. Let me say we are not going to be representing NFIB's position on that.

I will point out—and I use the phrase “intellectual disconnects”—one of the problems with the way the mandates work in the Clinton plan is that it is so difficult to understand what you may or may not pay.

For example, a sole proprietor would pay one piece, 7.9 percent, plus the employee share on himself. If you were a subchapter S corporation and you had undistributed income, you didn't pay yourself a salary, but you had undistributed income, none of that would be counted. And it goes on and on like that.

Chairman STARK. I understand. Let me try this on you, and your opinion of how your membership would react. I believe that many of my Republican colleagues like an individual mandate, the individual should be responsible rather than business or organization.

But if I took the position—let's leave dependent children out of this for a minute—that every one of your members had to have health insurance, had to have some minimum benefit, let's say about the Medicare level, and if they didn't have it they would be billed \$1,500 by the government—just to pick a number—that is 75 cents an hour on a 2,000 hour work year—and they would be given

it, you can go out and buy anyplace you want but if you don't have it, by default, you get it from the Federal Government. And let's say it is Medicare and you are billed \$1,500. If you are poor or under two times poverty, you are relieved from the \$1,500.

How would they react to that? That is a pretty tough mandate. You must have it, you can get it anyplace you want, but you have to have this minimum level of benefit, that presumably you could get for \$1,500.

Mr. SMEDSRUD. Most of our members have insurance. Most of our members I think recognize the responsibility to have insurance. The thing we need to do in this country is move everybody toward that recognition.

Chairman STARK. Would that kind of an edict trouble you?

Mr. SMEDSRUD. I am not sure if the number is the right number. I think people are stepping up and are willing to pay something. I think that is the sense of our members; that is the sense of a lot of people in agriculture, that we all have to contribute in some way.

The part of the problem we have is that it seems like now that, the more you make, the less you pay; and the less you make, the more expensive it is. And we have to even that out in some way.

And I go again to the question of the complexities on the way the administration wants to even that out.

Chairman STARK. Well, although as we learn so often in this committee, simple is not necessarily fair. And that is a problem that we often have.

Mr. Bross, just a question. The major concern for AIDS patients is the high cost of prescription drugs. Let's set aside for a minute the restriction on drugs.

Do you think that the President's plan adequately addresses the problem of prescription drug costs? And do you have any suggestions you might offer in that area?

Mr. BROSS. It is certainly an acknowledgment of the issue. Whether it goes far enough would be a subject of debate. We are continuing to work with members of the White House staff to provide them with the information that they need from our constituents so they can make that fair assessment.

But it is certainly a step in the right direction.

Chairman STARK. Would you have any confidence in a voluntary system?

Mr. BROSS. No.

Chairman STARK. Thanks.

Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

I think it is useful, actually, to look at the poll Mr. Smedsrud conducted among his folk. And you find on the last page that 93 percent of those in the poll currently have health insurance.

Mr. THOMAS. About 6 percent don't. And 1 percent don't know for sure. You are talking about a universe that feels a responsibility even if it is out-of-pocket to in fact do that. It sounds to me like a conservative, typical farmer.

And then take a look at what is the most important issue related to health care reform to you. Number one, either very important, or somewhat important, 92½ percent of them having the guarantee

that your insurance cannot be canceled if you change jobs, become ill or use health care services often. They are willing to pay for it, but they are concerned about the availability. And the choice and the quality issue is also clearly reflected in the policy in terms of people wanting to make their own choice in defining what they pay for their quality. I think this frankly is a bit more of a profile on more than just the rural group that you have studied. It is much more reflective of what is going on out there among the more folk rather than fewer.

And interestingly enough, they threw in one question: Do you favor an IRA-type program that would offer lower premiums but higher out-of-pocket costs for routine medical expenses. Forty-nine percent said yes. So half of them are willing to pay more out-of-pocket if they gave them this kind of a structure, the key point being that when you begin looking at the various plans to solve the problem, you have really got to look at what the plans have in common and then understand what I think is becoming universal agreement, and that is everybody is talking about that universal coverage costs money, but even your folks think that the real problem is to make sure they have it available.

One of the things I have had a hard time doing with the Clinton plan is taking a look at what they say they are going to do and how they are going to do it, and figuring out why they had to put some of the things in there that they did to bring about what they said they were going to do.

You know, the National Health Board, the entire structure of the alliances, I think we talked earlier today, if you essentially pull those out, provide some other aspects to it, that gives you that guaranteed package, but you can lock that in on a structural point of view. I don't see not getting to their goals by not having those components. In fact, by having those components, there is an enormous cost to be paid, not just in terms of dollars and cents, but in choice, innovation, in making things happen.

So in terms of your testimony, I can't, for the life of me, figure out why you have to have their kind of an alliance mandated their way to get the savings that they are talking about.

Obviously America is familiar with associations and cooperatives. There are a number of ways to get them. The argument was that voluntarily you can't make it happen. There are ways to mix and match with government and the private sector working together to create a number of universes, both government and private, to guarantee that that occurs, rather than a uniform, single, mandated system, which I think is partly your concern.

Mr. SMEDSRUD. Another point that comes out of the survey is the question of who do you believe could best solve problems. Only 2 percent thought government, but for the private sector, that is only about 30 percent thought they should leave it in the private sector. You have to make changes to it. The voluntary alliances work if you get rid of the idea of cherry picking, if you do some form of rating reform.

I was in Texas to give a speech to a farm group, and one farmer, 35 years old who is HIV positive, had some concerns about this plan. This is a third-generation farmer. He had a plan that right now pays \$2 million lifetime maximum. The question he asked is,

"will I be guaranteed to continue my plan?" Our answer was, no, you will not be guaranteed to continue the plan you now have. You will be guaranteed something. You won't ever really know what it is.

Granted, that is a lot better than the current situation for somebody that doesn't have insurance—at least he gets something. But for those that got, we don't really know what they are going to get. And they are going to have to get rid of what they already have.

Mr. THOMAS. The majority of Americans have insurance, so the doubt created is in a political group who are going to be putting pressures on this as more specifics come out. If we can do at the national level the insurance reforms you indicated in terms of small group reform, universal coverage, do something significant and meaningful on malpractice, simplify the administrative structure, encourage other things, that there is a lot that is going on now in the private sector that can be enhanced with this national umbrella.

Dr. Ehrenkranz, let me reinforce the frustration the chairman and I have the way this ridiculous process counts money. Everybody knows that there is a cost-benefit ratio to preventive care in a number of areas. And we are sitting here spending \$1 and getting zero in return.

I urged the First Lady to throw out the current budget process and figure out a new way to do it so we could get credit for it because we could put together a much more realistic plan in terms of what it costs and how much we get back.

But for all of us in this business, I want to share the frustration that we will be putting things in a plan that we know will produce money in a 5-year period, 10-year period, a lifetime. In addition, it will create a better quality of life, and that we have to pay up front, real dollars for every one them, and don't get any credit for it in the system. That is really frustrating when you are trying to put together a real-world package, because, "we have to deal with real-world problems."

Finally, a specific concern I have in terms of particular groups, and AIDS folks are one that concern me about the mechanism of these regional alliances and how they are structured. To a certain extent, although becoming less so, unfortunately, there are nevertheless concentrations of people who are HIV positive, and who in fact have been diagnosed as having AIDS, not evenly disbursed across the population.

One of my real fears is that as we get into this business of creating alliances, regional alliances, let's say in a State like California where it is clearly going to be a sub-State set, it may or may not be that consolidated metropolitan statistical area. You wind up in a very real political fight akin to redistricting in terms of where you draw the lines and in terms of who is going to accept the cost—not so much the hidden cost, now the very real cost of these various dependent populations.

Doctor, you have that same concern as well, and that is the last thing we want—a structure that creates political footballs out of real people in terms of where we are going to stick them under what kind of a structure. And the way this is outlined—

Chairman STARK. If the gentleman will yield, I am doubly worried because the insurance companies will all hire my colleague who is an expert at gerrymandering.

Mr. THOMAS. That is the last thing we want out of a plan that advisedly says we are going to solve the problems, because the way they have structured this creation of the alliance, the drawing of the alliance, who is going to pay and how you are going to pay it, almost guarantees that you are going to have these kinds of political fights. Do you have any concern on that?

Mr. BROSS. I think you have put your finger on our key concern. The necessity to address risk-adjustment issues is key to making this whole plan work. And be it cancer or heart disease or AIDS or prostate cancer, whatever, it is important that the risk-adjustment mechanism takes into account the concentration of people with AIDS, in your specific example.

Mr. THOMAS. It only increases when that universe becomes smaller and less directly representative of the broader constituency.

The other problem I have with this plan is that basically it works or doesn't work on risk adjustment. We just heard some pretty impressive experts tell us that you can get 20 to 40 percent of the real adjustment out of a risk-adjustment mechanism.

To me that is an extremely low percentage to invest this whole new structure and mandate this whole new arrangement, and then hope you get better than a 20 or 40 percent realignment to the structure. You are going to deny people real programs if you don't get it right. That is why I talk about keeping a private-sector option available and not imposing this current structure, because frankly, the people who are supposed to be able to tell us how to do risk adjustment basically tell us they don't know how to do risk adjustment.

Chairman STARK. Let me ask, if I may, if the gentleman has concluded, both Dr. Ehrenkranz and Mr. Bross, and Mr. Smedsrud too, I was unaware, reading the President's plan, that the alliances cannot cut across State lines or MSAs. The alliance at a minimum has to take in a whole metropolitan statistical area.

But what I didn't realize is that the plans within an alliance have no restriction. They can geographically gerrymander, if you will, and just pick up wards or precincts, other areas in which they choose to operate and exclude others. In other words, in a variety of areas you could geographically, as a plan, restrict your open enrollment street by street, neighborhood by neighborhood.

Does that give you any concern, Mr. Bross?

Mr. BROSS. It gives us grave concern because that is exactly the situation people with HIV and AIDS are facing in today's system. While we are focusing on some of the key concerns that the AIDS community has for the Clinton plan, I would just go back to some—

Chairman STARK. Castro wouldn't have an insurance company within 5 blocks.

Mr. BROSS. I would just go back to some of the other elements that are essential, whatever sorts of health care reform plan we come up with, to make sure we do have universal access, universal

coverage. You are talking now about the key component of the plan that causes us the most concern.

Chairman STARK. Dr. Ehrenkranz, do you see mischief in that oversight?

Dr. EHRENKRANZ. I see mischief. But remember, physicians and health care providers have chosen to place their offices in different locales. One of the other concerns, certainly, is with underserved areas, in urban areas, suburban, and rural areas, and one of the things that is addressed by the Clinton plan is the need to increase provider capacity and availability.

Chairman STARK. Let me try something on you. It always has seemed to me, and I don't say this either pejoratively or with disrespect, if you want doctors to practice in rural areas or the Anacostia area of the District of Columbia, pay them, they will go down there. But the insurance companies aren't going to go in there. You and I know that. We have evidence here that Prudential will not come into the District of Columbia because it will want to open their entire provider network to Medicaid benefits. They are on record.

What I am suggesting is that unless there is an open enrollment structure, that isn't enough. I am just saying there are two points, as my colleague from California so happily pointed out before, there are two issues. There is coverage and there is access. We all know that a hell of a lot of people with Medicaid coverage have no access. So a lot of people have access through the emergency room, but they are not going to get coverage.

Now, we can provide some policy, but if you are living 100 miles, figuratively or literally, from the provider, we have a problem. And somehow it seems to me at least on the coverage side we ought to open the enrollment in every plan so that a poor population or HIV-positive population can select any plan, and the plan is transparent. When this person walks in the door with that card, the card is silent as to why you are there, whether you live in a rural area—you could limit Redwing, but you can still go to Rochester if you choose. If you happen to think that Mayo is going to provide you better care, you can pack up, drive, hitchhike and get care. But if they are allowed to exclude that, then—did Redwing make the boots I used to wear?

Mr. SMEDSRUD. Yes. But the alliance would have the authority, from my reading of it, to make a lot of those decisions in terms of it could save the health plan.

Chairman STARK. That is what I thought. But it very clearly says that the health plan may limit its geographic boundaries. It could go further. The health plan can refuse even open enrollment within the district they choose to serve if in their opinion they decide that they are up to capacity. Being up to capacity is an art form that any health plan administrator can decide. You walk in the door and I don't like you, I am up to capacity right then.

What I am getting at is in this plan, as I said earlier, is an artful design to teach people how to redline or exclude people. The only way I know how to not do that is go the other way and just say, We have to make it not only say you have to let them in, but make sure you are there to service them when they come. That is something that I think no plan really has addressed.

The coverage is easy. Again, how do you get hospitals and doctors and nurses and pharmaceutical services out in rural areas and/or impacted inner-city areas. We are not very good at that. We have some ideas but for all we have tried, we are inadequate in every department, both in rural and inner-city areas. I will take the coverage and then we will go on to the next step, it doesn't have to get done in 1 year. But I think in the testimony that you are providing, the constituencies you represent need both. And we will try to get them.

Thanks for helping us today. Stay in touch with us. We will be at this for many more months. We appreciate your continued advice. Thank you.

[The following was subsequently received:]

March of Dimes
 Birth Defects Foundation
 National Government Affairs Office
 1901 L Street, N.W., Suite 260
 Washington, DC 20036
 Telephone 202 659 1800
 Fax 202 296 2964



November 8, 1993

Congressman Pete Stark, Chairman
 Subcommittee on Health
 Committee on Ways and Means
 U.S. House of Representatives
 Washington, D.C. 20515

Dear Mr. Chairman:

The March of Dimes is pleased to learn of your interest in assuring needed preventive care is available to pregnant women. Your comments during the October 21st hearing were very enlightening regarding the need for emphasis on the cost effectiveness of prenatal services.

For the record of your Subcommittee's October 21, 1993 hearing, we would like to submit the attached three short pieces documenting the prevalence of smoking among women of childbearing age, the health consequences, and the cost-effectiveness of smoking cessation for pregnant women.

Thank you for your interest in the health of mothers and babies and your leadership in the shaping of national health care reform policy.

Sincerely,

Richard A. Ehrenkranz, M.D.
 Public Policy Fellow

Vivian Gabor, M.P.H.
 Senior Associate
 Federal Affairs

Enclosures for Submission to the Record:

- 1) Excerpts from: Birth Defects and Infant Mortality, March of Dimes Birth Defects Foundation, December 1991.
- 2) Excerpts from: Monthly Vital Statistics Report, Vol. 42, No. 2, Supplement, July 8, 1993.
- 3) Marks, J., Koplan, J.P., Hogue, C. J.R., and Dalmat, M.E., "A Cost-Benefit/Cost Effectiveness Analysis of Smoking Cessation for Pregnant Women", Amer. Journal of Preventive Medicine, Volume 6, Volume 5, pp. 282-289.

Excerpt: Cost Effectiveness of Smoking Cessation
As a Component of Prenatal Care (pp. 70-71)

Birth Defects and Infant Mortality

Kay A. Johnson

Infant Mortality Report Series
Volume I, Number Two

March of Dimes Birth Defects Foundation • December 1991

The example of smoking cessation as a prenatal intervention focuses on prevention of low birthweight. However, it is an excellent example of what prevention research can provide – effective interventions that can be widely applied to save lives and save money.

An estimated 20% to 25% of pregnant women in the United States smoke cigarettes, and smoking rates are higher among low-income women. A pregnant woman who smokes is about twice as likely as her non-smoking counterpart to have a low-birthweight baby. Cigarette smoking by pregnant women has been found to lead to increased risk of perinatal mortality, in addition to low birthweight. Some researchers have estimated that cigarette smoking is the leading known cause of low birthweight, accounting for 21% to 39% of all low-birthweight births.

The nation's health objectives for the year 2000 aim to reduce tobacco use by pregnant women to no more than 10%. Widespread use of smoking cessation programs would contribute to achievement of such a reduction. Recent studies have found that structured smoking cessation programs for pregnant women are cost effective – with 15% of pregnant women quitting smoking.

A recent analysis of the cost-benefit of smoking cessation programs for pregnant women found that by preventing low birthweight, with its attendant costs for neonatal intensive care and treatment of disability, \$6 could be saved for every \$1 invested (Figure 38). When neonatal intensive care costs are considered alone, savings were

estimated at \$3.31 per \$1 spent. Since tobacco use is associated with perinatal mortality, a national smoking cessation program could prevent an estimated 338 fetal and newborn deaths.

The example of smoking cessation as a preventive intervention focuses on prevention of low birthweight. However, it clearly demonstrates what prevention research can provide – effective interventions that can be widely applied to save lives and save money. In the future, more effective interventions may be recommended for use nationwide in the prevention of birth defects from exposure to alcohol and illicit drugs (see discussion of Figure 39).

Birth Defects and Infant Mortality Figure 38

Cost-Effectiveness of Smoking Cessation
As a Component of Prenatal Care

39,000 excess low-birthweight births → 5,900 preventable
One out of six excess low birthweight births preventable



Savings of \$6 for each \$1 spent
This can double the cost savings for prenatal care

Source: Division of Reproductive Health
Centers for Disease Control
Calculations by March of Dimes

Monthly Vital Statistics Report



Final Data From the CENTERS FOR DISEASE CONTROL AND PREVENTION/National Center for Health Statistics

Advance Report of Maternal and Infant Health Data From the Birth Certificate, 1990

Contents

Introduction	1
Medical risk factors	2
Tobacco use	3
Alcohol use	4
Maternal weight gain	5
Obstetric procedures	6
Complications of labor and/or delivery	6
Method of delivery	7
Abnormal conditions of newborn	8
Congenital anomalies	8
References	9
List of tables	11
Technical notes	29

Introduction

Beginning with the 1989 data year, information has been available on a large number of important maternal and infant health factors affecting birth outcome. These include medical and

life-style risk factors of pregnancy and birth, obstetric procedures performed, method of delivery, abnormal conditions and congenital anomalies of the newborn, expanded information on birth attendant and place of delivery, and questions on the Hispanic origin of the parents. This major enhancement of medical and health data available on an annual basis for mothers and babies greatly expands the scope of information on pregnancy outcome in the United States (1,2).

The new information was first presented in an earlier report (3). This is the second report focusing on the new data. Expanded information on 1990 births by attendant and place of delivery as well as Hispanic origin of the parents was also presented in an earlier report (4).

The data available for 1989 and subsequent years reflect a significant departure from prior years in birth certificate content and format. Checkboxes are used extensively to obtain the detailed medical and health data

requested. Uniform reporting and a clear focus on the requested data are facilitated by this new format.

As of 1990, all States (except Oklahoma) and the District of Columbia had implemented the new birth certificate. Oklahoma revised its certificate as of 1991. Although most States adopted the revision in its entirety, there are some exceptions. Some States did not include every item in their revisions: Items such as tobacco and alcohol use are not reported by every State. In addition, some States reporting a given item did not include every checkbox for that item. As a consequence, the total number of births in the areas reporting each factor or condition and the number of births for which the information is not stated will vary to reflect the differing number of States reporting the specific factor or condition. These variations are indicated in the tables.

Now that the new medical and health data have been available for 2 years, some improvements have been

Acknowledgments

This report was prepared in the Division of Vital Statistics. Stephanie J. Ventura, Selma M. Taffel, and T. J. Mathews of the Natality, Marriage, and Divorce Statistics Branch wrote the report. Donna Wright prepared statistical tables and Thomas Dunn provided content review. Manju Sharma provided computer programming support. The Registration Methods Branch and the Technical Services Branch provided consultation to State vital statistics offices regarding collection of the birth certificate data on which this report is based. This report was edited by Arlett Brown and typeset by Zung T. N. Le of the Publications Branch, Division of Data Services.



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control and Prevention
National Center for Health Statistics



43 percent risk of another heavier-than-average baby.

The likelihood of a preterm birth (gestation of less than 37 completed weeks) was 20 percent or greater for mothers with hydramnios, eclampsia, incompetent cervix, previous SGA infant, and uterine bleeding compared with 11 percent for all births.

Tobacco use during pregnancy

Cigarette smoking during pregnancy has long been associated with reduced infant birthweight (8,9), intra-uterine growth retardation, and preterm birth. Low birthweight in turn is one of the major predictors of infant mortality and infant and childhood morbidity. Sudden infant death syndrome (SIDS) in particular is highly associated with low birthweight (10-12). Additionally, maternal smoking during pregnancy has been shown in many studies to be associated with a sharply elevated risk of SIDS even after other risk factors such as low birthweight have been taken into account (10,11). Finally, past studies have estimated that the number of infant deaths could be reduced by 10 percent if pregnant women did not smoke (11,13). The mechanisms through which tobacco use adversely affects pregnancy outcome have been reviewed elsewhere (8,14).

The birth certificates of 45 States and the District of Columbia reported tobacco use during pregnancy in 1990. The information was not available for California, Indiana, New York, Oklahoma, and South Dakota. The mother's smoking status was not reported on 4 percent of the birth certificates in the reporting States (table 2).

Smoking during pregnancy was reported by 18.4 percent of women giving birth in 1990 compared with 19.5 percent in 1989. These levels are comparable to those reported in the 1988 National Maternal and Infant Health Survey (NMIHS) (15). As in 1989, white mothers in 1990 were more likely to smoke than were black mothers, 19.4 percent compared with 15.9 percent. The smoking rate was highest for mothers aged 18-19 years (22.5 percent) and lowest for teenage

mothers under 15 years (7.5 percent) and for mothers in their forties (12.3 percent).

The same variation in smoking by age was observed for white mothers, but for black mothers, smoking was most prevalent at ages 25-34 years, with rates of 21.1-22.5 percent compared with 9 percent or less for teenage mothers.

Among all mothers who smoked, a majority (59 percent) smoked no more than half a pack of cigarettes (10 or fewer) per day. One in five smoked five cigarettes or less daily. However, more than a third smoked 16 cigarettes or more per day. Younger mothers tended to smoke fewer cigarettes; of teenage mothers who smoked, two-thirds smoked half a pack or less per day. The average number of cigarettes smoked increased steadily with advancing maternal age.

White mothers were not only more likely than black mothers to smoke during pregnancy, but those who were smokers smoked much more. Thirty-seven percent of white women compared with 21 percent of black women smoked 16 cigarettes or more per day. Conversely, 33 percent of black mothers compared with 17 percent of white mothers smoked five cigarettes or fewer per day.

Several studies have indicated that Hispanic women are much less likely to smoke than non-Hispanic women (16-18). Birth registration data corroborate these findings (table 3). Overall, 7 percent of Hispanic mothers were reported to have smoked during pregnancy compared with 21 percent of white non-Hispanic and 16 percent of black non-Hispanic mothers. Mexican, Cuban, and Central and South American women were particularly unlikely to smoke, 3-6 percent compared with Puerto Rican mothers, 14 percent.

The highest smoking rates for Hispanic women overall were for mothers aged 18-34 years, 7 percent. There was very little variation by age in the percent of smokers for Mexican, Cuban, and Central and South American mothers. Among Puerto Rican mothers, the percent of smokers varied more, 7-14 percent. By contrast, the proportion of smokers among non-Hispanic

women varied substantially according to mother's age. Among white non-Hispanic mothers, the proportion ranged from 13 percent (mothers 35 and older) to 33 percent (mothers aged 18-19 years). Among black non-Hispanic mothers, the proportion ranged from 2 percent (teenagers under 15 years) to 23 percent (women aged 30-34).

Maternal smoking is relatively rare among Asian women. The proportions in 1990 were 2 percent for Chinese mothers, 4-5 percent for Filipino and other Asian and Pacific Islander mothers, and 8 percent for Japanese mothers. (Tabular data are not presented in this report.)

Among mothers giving birth in 1990, one-third with 9-11 years of education were reported to have smoked during pregnancy, seven times the rate reported for college graduates, 5 percent (table 4). Women with a grade school education or less (0-8 years) and women who were high school graduates were about equally likely to smoke, 19 and 21 percent, respectively. The relationship of maternal smoking and educational attainment is similar for white and black mothers. However, white mothers with 12 years or fewer of schooling were 47-80 percent more likely than their black counterparts to smoke. For women with 1 year or more of college, however, the proportions of smokers were similar for white and black mothers.

Among mothers who smoked, those who had completed the fewest years of formal education smoked the most. In 1990, 48 percent of mothers with a grade school education or less smoked at least half a pack of cigarettes per day compared with 29 percent of mothers who were college graduates. The relationship between the number of cigarettes smoked and educational attainment was similar for white and black mothers. In each educational attainment category, white mothers smoked more cigarettes than black mothers, but the racial disparity narrowed as educational attainment advanced.

Maternal smoking has a severe adverse impact on infant birthweight. Babies born to mothers who smoke are

at substantially elevated risk of low birthweight (11.3 percent) compared with babies born to nonsmokers (6.1 percent) (table 5). Although the risk of low birthweight tends to decline with advancing maternal age, the disparity in low birthweight by maternal smoking status actually increases with increasing maternal age. For example, among mothers 18–19 years, 11 percent of births to smokers compared with 9 percent of births to nonsmokers weighed less than 2,500 grams (5 lb 8 oz). Among mothers aged 25 years and older, however, the incidence of low birthweight was more than twice as high for births to smokers, 11–16 percent compared with 5–7 percent. The relationship of maternal smoking and low birthweight can be viewed in another way: Although mothers who smoke account for 18 percent of all births, they account for 28 percent of all low-birthweight births.

White and black infants alike were adversely affected if their mothers smoked during pregnancy. Among white mothers, 9.4 percent of smokers compared with 4.8 percent of nonsmokers gave birth to a low-birthweight infant. The proportions for births to black mothers were 21.2 percent for smokers and 11.7 percent for nonsmokers. The differential by smoking status was substantial for white and black mothers in all age groups and tended to increase as age of mother advanced. Regardless of age and smoking status, however, black babies were at considerably elevated risk of low birthweight compared with white babies.

Another aspect of maternal smoking that affects the levels of low birthweight is the number of cigarettes smoked daily during pregnancy (9). Although the differential in low birthweight is greatest when smokers as a group and nonsmokers are compared, heavier smoking tends to elevate the low-birthweight levels even further. In 1990 the incidence of low birthweight increased from 10 percent for births to mothers who smoked five cigarettes or fewer to 14 percent for births to mothers who smoked 1 1/2–2 packs daily. For white mothers with comparable smoking levels, the increase was

from 8 to 12 percent, and for black mothers, the increase was from 18 to 32 percent. Babies born to the heaviest smokers among white and black women alike were at two to three times the risk of low birthweight as were babies born to nonsmokers.

A Cost-Benefit/Cost-Effectiveness Analysis of Smoking Cessation for Pregnant Women

James S. Marks, MD, MPH, Jeffrey P. Koplan, MD, MPH,
Carol J. R. Hogue, PhD, and Michael E. Dalmat, DrPH

Research has shown that pregnant women who smoke cigarettes increase their risk of having low birthweight (LBW) infants. Recent randomized trials indicate that women who quit smoking early in pregnancy reduce their risk of delivering a LBW infant. Using various sources, we estimated the cost-effectiveness of a smoking cessation program for preventing LBW and perinatal mortality. Assuming the program would cost \$30 a participant and that 15% of the participants would quit smoking, we determined that a program offered to all pregnant smokers would shift 5,876 LBW infants to normal birthweight and would cost about \$4,000 for each LBW infant prevented. Since infants born to smokers are at 20% greater risk for a perinatal death, a smoking cessation program could prevent 338 deaths at a cost of \$69,542 for each perinatal death averted. Compared with the costs of caring for these LBW infants in a neonatal intensive care unit (NICU), smoking cessation programs would save \$77,807,054, or \$3.31 per \$1 spent. The ratio of savings to costs increases to more than six to one when we include reducing long-term care for infants with disabilities secondary to LBW in the benefits from smoking cessation programs. These findings argue for routinely including smoking cessation programs in prenatal care for smokers. [*Am J Prev Med* 1990;6:282-9]

Cigarette smoking by pregnant women has been shown repeatedly to lead to increased risk of low birthweight (LBW), intrauterine growth retardation, and perinatal mortality.¹⁻⁷ In fact, several reviews of the causes of LBW have considered cigarette smoking to be the leading known cause of LBW in the United States and the developed world, accounting for 21% to 39% of all LBW births.^{1-4,6} Because LBW is associated with the majority of infant deaths, efforts aimed at preventing LBW are central to reducing infant mortality. Further, the intensive care required to assure the survival of LBW and pre-term infants is expensive, costing an estimated \$11,700 to \$39,400 in 1984 per average LBW infant.⁸ However, until recently, little evidence has been available from well-controlled studies concerning the effectiveness of smoking cessation efforts aimed

at pregnant women. Such evidence has now begun to accumulate.⁹⁻¹⁵

Approximately 21% of pregnant women in the United States smoke cigarettes, and the rates are even higher among those women whose risk of having a LBW infant is already high, namely, the poor, the poorly educated, teenagers, and blacks.¹⁶⁻¹⁸ For each of these groups, the risk of having a LBW infant doubles if the woman smokes.^{1,2,4,5} Overall, about 15% to 20% of women who smoke quit on their own when they learn they are pregnant. Those who quit on their own are generally lighter smokers and better educated than those who continue to smoke.¹⁸

In this study, we estimated the cost-effectiveness of a smoking cessation program for pregnant women to reduce LBW and perinatal mortality. We used as a definition of a cost-effective program the one discussed by Doubilet et al.¹⁹ To be considered cost-effective the program must either "improve health outcome and save money or deliver a health benefit at an acceptable cost." We did this first by estimating the number of LBW infants and perinatal deaths that could be prevented if all pregnant women in

From the Center for Chronic Disease Prevention and Health Promotion (CCDP&HP) (Marks and Koplan) and the Division of Reproductive Health, CCDP&HP (Hogue and Dalmat), Centers for Disease Control, Atlanta, Georgia.

Address reprint requests to Division of Reproductive Health, Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control, Atlanta, GA 30333.

the United States received the program early in pregnancy. Costs and savings were then assessed with these numbers. Finally, we examined alternative assumptions to assess their impact on the estimated costs and benefits.

METHODS

We first assessed the LBW and perinatal mortality attributable to maternal smoking during pregnancy. We then examined the costs of a smoking cessation program (e.g., booklets and additional personnel costs). Costs and outcomes were estimated for the population of women in the United States who deliver babies each year. Using 1986 as the base year, we adjusted all costs to 1986 dollars using the Medical Care Price Index (MCPI). The question we examined was "What would be the projected costs and outcomes if all pregnant women who smoked cigarettes took part in a smoking cessation program early in their pregnancy?" Because not all women enter prenatal care early, our model gives theoretical estimates of the number of deaths and LBW infants that could be prevented. However, the cost-to-savings ratio is not changed, because the costs and benefits would apply only to those women entering early enough to receive the intervention.

Smoking Rates and Expected Cessation Rates

We estimated smoking rates from the 1985-86 Behavioral Risk Factor Surveillance System (BRFSS), which was based on a sample of American women from 25 states and the District of Columbia.¹⁶ Overall, 21% of women in the survey smoked during their pregnancy, as compared with 30% of nonpregnant women. This result gives estimates somewhat lower than estimates (25%) from a national survey of smoking in pregnancy conducted in 1980.²⁰ Although the BRFSS is from only 25 states, we chose the more recent estimate from the BRFSS because it was in keeping with trends toward fewer persons smoking and would yield more conservative estimates of impact (i.e., total number LBW infants prevented).

Earlier randomized trials of smoking cessation among pregnant women demonstrated increased cessation rates over usual care from 4% to 29%, with higher rates of quitting found in studies that limited the intervention to women whose initial prenatal care visit occurred early in the pregnancy.⁹⁻¹⁵ We assumed in our model the cessation rate of 15% based on a weighted analysis of previously published trials. When we estimated the cost-effectiveness of our model program, we did not allow for

any impact from women who reduced the amount they smoked, but who did not actually quit. Further, we only considered the net effectiveness of the program and did not include cessation that occurred spontaneously.

Costs of Cessation Programs

Interventions varied substantially among cessation programs. In some programs, obstetricians specifically told their patients to quit smoking and gave them a booklet.¹² In others, after an initial counseling session, patients received booklets through the mail each week and motivational messages through a prerecorded phone service.¹³ In another program, staff assigned solely to interventions visited patients, called them on the telephone, and mailed them educational materials.⁹

To estimate costs, we considered a model program to consist of a single 15-minute counseling session, simple instructional materials (\$5 a patient) to be given to the patient, and two follow-up telephone calls. Staff time was estimated to cost \$15 an hour, and each telephone call was expected to take 30 minutes of staff time, including call-backs and chart completion. We assumed that a nurse or health educator would carry out such a program. We also added 25% to the cost of the staff and materials as practice overhead and to cover initial staff training. This model program was estimated to cost \$30 a participant. No costs were added for biochemical testing of smoking status; such testing has been used in some clinical trials to confirm patients' quitting status. Costs were not added for the clinician to question patients during subsequent prenatal visits to confirm their smoking status, since this is part of routine care.

The only studies for which cost data have been published estimated the costs of their intervention programs at \$7.13 a patient and \$11 a patient respectively.^{21,22} Both were relatively low-intensity interventions, and the investigators did not incorporate indirect costs in their estimates. However, in the sensitivity analysis, we examined the effect that the costs of programs of greater and lesser intensity (and cost) would have on the cost-effectiveness. We did not include the pension cost increases that might accrue resulting from longer lives of women who quit smoking.

Pregnancy Outcomes

A pregnant woman who smokes is about twice as likely to have a LBW infant as a nonsmoker.^{1-5,18} This excess risk increases with the amount smoked a

day and is independent of other predictors of LBW. For our baseline model, we used two as the average relative risk and 5% as the baseline risk of having a LBW infant. This baseline risk is derived from the range of LBW risk for nonsmokers in several previous large studies.^{1,3} In these studies, the percentage of LBW infants delivered by nonsmokers ranged from 3.5% to 5.2% in predominantly white populations and from 6.4% to 10.7% in black populations. This baseline estimate is also consistent with the expected LBW rate in the United States if the roughly 20% to 25% of such births attributable to smoking were prevented.

Finally, previous studies found that the increased risk of a perinatal death due to maternal smoking ranged from 1.03 to 1.38 times that of the risk among nonsmokers.^{1,3,7} We used a relative risk of 1.2 in our baseline model. We defined perinatal deaths as the sum of fetal deaths occurring at 20 weeks' gestation or greater, plus deaths of infants younger than 28 days of age. To estimate the number of perinatal deaths caused by smoking, we first calculated the attributable fraction of deaths due to smoking from the relative risk of death and the percentage of women smoking during pregnancy.²³ Then we multiplied this percentage by the total number of perinatal deaths registered in the United States.²⁴

Costs Averted

To estimate the short-term costs averted by a smoking cessation program, we used the costs per average birth for hospitalizing LBW infants minus those costs for normal birthweight infants. We assumed that normal weight infants born to smokers would accrue costs similar to normal weight infants born to nonsmokers. We also assumed that the cost of hospitalizing LBW infants was the same regardless of the smoking status of the mother.

We used \$27,003 (the middle estimate of \$23,639 in 1984 reported by the Office of Technology Assessment [OTA] adjusted to 1986 dollars) as the cost of neonatal intensive care per LBW infant.⁸ This estimate was reduced by \$520, the average cost of \$484 adjusted to 1986 for a normal delivery and outcome.²⁵ In addition, we assumed that only 50% of LBW infants would be hospitalized in neonatal intensive care units (NICUs). Although little information exists to indicate what proportion do receive intensive care, most likely many of the larger LBW infants do not.²⁶ However, the cost of hospitalizing a LBW infant who does not need intensive care likely is more than the cost of routine hospital care for a normal newborn. We did not add any additional

costs accrued by LBW infants who required longer hospital stays even though they were not in NICUs.

In addition to estimating the short-term costs averted by a smoking cessation program, we used OTA estimates to examine the potential cost savings from preventing excessive long-term impairments and associated care for LBW infants with conditions such as cerebral palsy, mental retardation, or both.²⁷ The OTA study estimated the lifetime cost of special services from 1 to 35 years of age because of LBW for each LBW birth to range from \$8,540 to \$22,520 depending on the cost assumptions and discount rate used. We chose to use the low-cost care estimate discounted at 4% for an average discounted cost of \$13,080 per LBW birth.

We did not include among the savings the lowered health care costs among women who quit due to fewer maternal complications or chronic conditions (heart disease, cancer) averted. Nor did we include the lifetime earnings of the infants whose deaths would be prevented.

Sensitivity Analysis

We tested the effect that varying cessation rates among smokers would have on the cost-effectiveness by examining the cost per LBW infant prevented when rates of quitting ranged from 5% to 25%. The cost per participant was varied from \$5 to \$100 to reflect the broad range of interventions described in the literature.⁹⁻¹⁵ We also varied the estimate of the proportion of LBW infants requiring NICU care from a low of 33% to a high of 67%. Although the average relative risk of LBW from smoking is generally accepted as 2.0, we varied the relative risk of having a LBW infant from 1.5 to 2.5 in our sensitivity analysis to see if the cost-effectiveness would be substantially affected. We also examined how the high baseline risk of LBW often found among women attending public clinics would alter cost-effectiveness. For the relative risk of perinatal deaths, we chose estimates close to the range found in the literature, 1.1 to 1.4.^{1,3,7}

Last, we examined both "best case" and "worst case" scenarios. The worst case consisted of low cessation rates (5%), high cost per participant (\$100), and a low relative risk (1.5). The best case comprised, respectively, 25%, \$5, and 2.5.

RESULTS

Baseline. We applied our estimates to the 1986 birth cohort of 3,731,000 infants and found that about 783,510 were born to women who smoked during their pregnancy (appendix 1).²⁸ These infants' ex-

cess risk of LBW led to an additional 39,176 LBW births. A program that would reach all 783,510 female smokers early in their pregnancy and enable 15% of these women to quit would cost \$23,505,300 and would prevent about 5,876 LBW births at a cost of \$4,000 per LBW birth prevented.

Prevention of perinatal deaths. Given a relative risk of 1.2 for perinatal deaths among the infants of pregnant smokers and the fact that 21% of pregnant women smoke, we estimate that nearly 5% of the 55,840 perinatal deaths reported in the United States in 1985 were caused by maternal cigarette smoking (appendix 2). A typical smoking cessation program with a cessation rate of 15% would prevent about 338 deaths a year and cost an estimated \$69,542 per death prevented. If we assume a life expectancy of 75 years per additional survivor, discounted at 4%, the costs are \$2,934 a year of life gained.

Estimated costs averted. We estimated that if smoking cessation counseling were available to all pregnant women who smoke, the net savings in NICU hospitalization costs would total more than \$77,807,054 and would save \$3.31 for every \$1 spent on the program (appendix 3). An additional \$76,858,080 in long-term costs, or \$3.26 per \$1 spent on smoking cessation programs, would be averted by preventing disability among LBW infants who survive.

Sensitivity Analysis

The cost of the smoking cessation program is the principal factor affecting the cost per LBW birth pre-

vented (Table 1). At \$100 a participant, the cost increases from \$4,000 to \$13,333 for each LBW infant prevented. The cessation rate among participants in the cessation program also can affect the cost-effectiveness substantially. For example, if only 5% of the women quit and the baseline cost estimate is used, then the cost per LBW birth prevented increases to \$12,000.

Because smoking doubles a woman's risk of LBW independently of other risk factors, the population's baseline risk of LBW becomes important in determining the overall cost-effectiveness of a smoking cessation program. A high baseline risk (12%) of LBW—such as might occur in a public clinic population—lowers the costs to \$1,667 per LBW birth prevented. No other single factor that we examined alters the cost-effectiveness per LBW birth prevented as greatly as those just discussed. The cost per perinatal death averted ranges from \$36,210 to \$136,659 when a higher or lower relative risk of perinatal death is used. Under the worst case scenario, the cost would be \$80,000 for each LBW prevented; under the best case scenario, it would be only \$267 for each LBW birth prevented.

DISCUSSION

When we apply our cost-effectiveness analysis to a program of smoking cessation in pregnancy, we find that a typical case would cost \$4,000 for each infant whose birthweight is shifted from low to normal. However, the savings from preventing costly hospitalizations for LBW infants and long-term care

Table 1. Sensitivity analysis of cost-effectiveness of a smoking cessation in pregnancy program for low birthweight

Factor considered	Range	Cost per LBW prevented (in dollars)	Ratio of NICU costs averted to costs of program
Percentage cessation	5%	12,000	1.1:1
	25%	2,400	5.5:1
Cost per participant	\$5	667	19.8:1
	\$100	13,333	1:1
Baseline risk of low birthweight	3%	6,667	2:1
	12%	1,667	7.9:1
Relative risk of low birthweight	1.5	8,000	1.7:1
	2.5	2,667	5:1
"Worst case" ^a		80,000	.17:1
"Best case" ^b		267	50:1

For a relative risk of perinatal death of 1.1, the cost per death prevented would be \$136,659 and cost per year of life gained would be \$5,766. For a relative risk of perinatal death of 1.4, the cost per death prevented would be \$36,210 and cost per year of life gained would be \$1,528.

For a low NICU hospitalization rate (33%) for LBW births, the benefit-to-cost ratio = 2.2:1. For a high NICU hospitalization rate (67%) for LBW births, the benefit-to-cost ratio = 4.4:1.

^aWorst Case: cessation Rate = 5%, cost = \$100, RR of LBW = 1.5.

^bBest Case: cessation Rate = 25%, cost = \$5, RR of LBW = 2.5.

for those infants who survive although badly handicapped are more than \$6 for every \$1 spent on such a smoking cessation program. Furthermore, approximately 5,876 LBW births and 338 perinatal deaths would be averted yearly, if all pregnant women who smoke received the program.

The benefit-to-cost ratio (6.6:1) of the program remains impressive even when more stringent assumptions than those we project for a typical case are considered or when the program is compared with other prenatal and perinatal prevention programs. Although the methods of the studies vary and direct comparisons of the ratios should be made cautiously, neonatal metabolic screening was found to have benefit-to-cost ratios of 1.8 to 8.9:1; maternal serum alpha-fetoprotein screening a ratio of 1.95 to 2.35:1; screening for Down's syndrome in women 40 years of age and older 1.1 to 2.6:1; and prenatal care 3.4:1.²⁹⁻³³

A study of the cost-effectiveness of neonatal intensive care for improving survival of very LBW infants found costs of \$52,200 in 1978 per additional survivor and \$2,540 per life year gained for infants weighing from 1000 to 1499 grams.³⁴ These figures are roughly comparable with those found here per additional survivor among infants born to women who were offered smoking cessation during pregnancy.

We chose assumptions of what a typical case would cost to give conservative but realistic estimates (i.e., somewhat high estimates of program costs and low estimates of adverse outcomes and costs averted). The smoking cessation rate chosen was near the midpoint of reported cessation rates, and we did not add a further reduction in smoking-related LBW from women who merely cut down the amount they smoked. Evidence does suggest that some women enrolled in smoking cessation programs do reduce the amount smoked, and this may also contribute to improved birthweight of their infants.^{3,7,9,11}

Prenatal programs working with women at high risk of LBW from other causes (e.g., young age, low education) might find lower cessation rates than we assumed here or would need more intensive, higher cost interventions. Yet because smoking's effect on LBW occurs even when other risks are controlled for, more LBW births would be prevented if the same number of women quit, thus tending to offset the greater costs of the program. In fact, one study conducted in such a population found very low costs per quitter using a self-help program.²¹

Many women, especially those at high risk, enter care late, when smoking cessation efforts are likely to be less effective. To achieve the estimates of

number of LBW births prevented and perinatal deaths prevented, the roughly 25% of women who enter care late would need to enter care early enough to benefit from smoking cessation programs.³⁵ However, the individual costs and benefits per LBW birth prevented estimated here would still hold for women who currently opt for care early in pregnancy.

Little information exists on the cost of adding smoking cessation to prenatal care. Reports of self-help programs estimated costs at \$7.13 and \$11 a participant.^{21,22} However, because most of the programs described in the literature were more intensive than self-help programs, we chose to estimate the costs using an intervention requiring more staff time plus practice overhead.

Our estimates of potential savings depend on the cost figures for hospitalization of LBW infants. The low OTA estimate (\$13,326 after adjustment to 1986 dollars) is based on the average costs for all LBW infants, including those who did not require intensive care.⁸ That figure gives very similar costs to OTA's middle estimate (\$27,003) when applied to the roughly 50% of the LBW infants estimated to need NICU care. These assumptions, coupled with the exclusion of costs for the longer than usual hospitalizations of LBW infants not requiring intensive care, should give conservative estimates of hospitalization costs averted. We chose a low cost basis for considering the effect of long-term care expenses from serious disabilities associated with LBW, such as cerebral palsy and mental retardation.²⁷ The estimate we used (\$13,080) was about 60% of the highest estimate in the OTA report.

Although some evidence has suggested that LBW infants born to smokers may not be as ill as those born to nonsmokers, other studies suggest that any difference that exists is not substantial.^{3,36,37} Accordingly, we assumed that the hospitalization costs of LBW infants born to smokers would be similar to the costs of LBW infants born to the general population.

The only other estimate in the literature on the economic costs of smoking during pregnancy found that infants born to smokers incurred a national total of \$267 million in extra costs (in 1983 dollars).³⁸ These authors did not consider long-term care costs. We found, using NICU costs alone, a total excess cost of \$519 million (the product of the excess number of LBW infants born to pregnant smokers, a 50% NICU hospitalization rate, and \$26,483 per NICU hospitalization divided by the total number of pregnant smokers). This difference is principally due to our using a higher rate of NICU admission (50% versus 42%), the higher costs associated with

adjustment to 1986 rather than 1983 dollars, and a higher cost per NICU hospitalization reported by the OTA even when inflation is taken into account.

We did not consider two sources of monetary benefits in our model. First, in looking at the issue of lifetime productivity, we assigned no value for infants who would have survived or for infants who would be born with normal intelligence instead of being retarded and requiring long-term care. A 1979 study of maternal serum alpha-fetoprotein screening estimated the value of a normal child to be \$13,824.³¹ If we use this value, our model program would substantially decrease the cost per death averted and further increase the estimated savings.

Also, we did not include those monetary benefits that accrue from the health benefits to the women themselves. For example, the societal economic benefits of quitting have been estimated to be from \$3,003 to \$13,594 depending on how much a woman between the ages of 35 to 39 smoked.³⁹ Although many women who quit during pregnancy may resume smoking after delivery, positive economic benefits from those who remain nonsmokers would have further increased the ratio of savings to program costs. During the pregnancy, improvements in maternal health would include decreased frequency of abruptio placentae and cesarean section as well as long-term health benefits.

In summary, smoking cessation programs for pregnant women could be expected to prevent several thousand LBW births and save several hundred lives each year. In addition, such programs would save more than \$6 per \$1 spent, more than doubling the overall cost savings attributed to the rest of prenatal care.³³ Based on this analysis and those documenting the health benefits and effectiveness of cessation programs, we conclude that physicians, third-party payers, managed-care organizations, and public health programs should offer this preventive service to all pregnant women who smoke.

We wish to acknowledge the thoughtful comments and reviews provided by Ronald Davis, MD, Richard Rothenberg, MD, and Kenneth E. Warner, PhD.

APPENDIX 1

Cost-effectiveness of a Smoking Cessation in Pregnancy Program for Preventing Low Birthweight

Baseline population characteristics	Source
Total births (A)	3,731,000 1986 Vital Statistics ²⁷

Percentage of smokers in pregnancy (B)	21	1985-86 BRFS Surveillance System ¹⁶
No. smoking pregnant women (C)	783,510	$A \times B$
Percentage baseline risk of LBW (D)	5	See text
Percentage excess risk of LBW infants among pregnant smokers (E)	5	See text
Excess no. of LBW infants born to smokers (F)	39,176	$C \times E$
LBW prevention		
Percentage cessation rate of typical smoking cessation program (G)	15	See text
No. of LBW births prevented by national program (H)	5,876	$F \times G$
Costs		
Cost of smoking cessation program per participant (I)	\$30	See text
Costs of smoking cessation program (J)	\$23,505,300	$C \times I$
Cost per LBW birth prevented	\$4,000	J/H

APPENDIX 2

Cost-effectiveness of a Smoking Cessation in Pregnancy Program for Preventing Perinatal Deaths

Baseline population characteristics	Source
Total perinatal deaths (A)	55,840 >20 wks gestation and <28 days of age ²³
Percentage of pregnant women who smoke (B)	21 1985-86 BRFS Surveillance System ¹⁶
Estimated relative risk of perinatal death for infants of smokers (C)	1.2 See text

APPENDIX 2

Baseline population characteristics		Source
Percentage of perinatal deaths attributable to smoking (D)	4.03	$B(C-1)/[B(C-1)+1]^{22}$
Excess perinatal deaths due to smoking (E)	2,250	$A \times D$
Percentage cessation rate of smoking cessation program (F)	15	See text
Deaths prevented by smoking cessation program (G)	338	$E \times F$
Total cost of national smoking cessation program (H)	\$23,505,300	See appendix 1
Cost per perinatal death prevented (I)	\$69,542	H/G
Cost per life year gained (discounted)	\$2,934	Life expectancy estimated at 75 years discounted at 4% = 23.7 years

APPENDIX 3

Estimated Costs Averted by a Smoking Cessation Program for Pregnant Women

		Source
Estimated LBW births prevented (A)	5,876	Appendix 1
Percentage requiring NICU care (B)	50%	See text
Excess cost per NICU admission (C)	\$26,483	OTA ⁸
Total NICU hospitalization costs averted (D)	77,807,054	$A \times B \times C$
Ratio of costs averted to program costs (E)	$\frac{\$77,807,054}{\$23,505,300} = 3.31$	D/program cost
Long-term care costs per LBW birth (F)	\$13,080	Study ²⁶

Total long-term care costs averted (G)	\$76,858,080	$A \times F$
Ratio of long-term care costs averted to program costs (H)	$\frac{\$76,858,080}{\$23,505,300} = 3.27$	G/program cost
Net ratio of costs averted to program costs (I)	6.58	$E + H$

REFERENCES

1. U.S. Department of Health, Education and Welfare. The health consequences of smoking for women: a report of the Surgeon General. U.S. Department of Health, Education and Welfare, Public Health Service, Office on Smoking and Health; 1980.
2. Meyer MB, Tonascia JT, Buck C. The interrelationship of maternal smoking and increased perinatal mortality with other risk factors. Further analysis of the Ontario Perinatal Mortality Study, 1960-1961. *Am J Epidemiol* 1974;100:443-52.
3. Meyer MB, Jonas BS, Tonascia JT. Perinatal events associated with maternal smoking during pregnancy. *Am J Epidemiol* 1976;103:464-76.
4. Niswander KR, Gordon M, eds. The women and their pregnancies. Philadelphia: W.B. Saunders; 1972.
5. Shiono PH, Klebanoff MA, Rhoads GG. Smoking and drinking during pregnancy: their effects on preterm birth. *JAMA* 1986;225:82-4.
6. Kramer MS. Intrauterine growth and gestational duration determinants. *Pediatrics* 1987;80:502-11.
7. Kleinman JC, Pierre MB, Madans JH, Land GH, Schramm WF. The effects of maternal smoking on fetal and infant mortality. *Am J Epidemiol* 1988;127:274-82.
8. U.S. Congress, Office of Technology Assessment. Neonatal intensive care for low birthweight infants: costs and effectiveness. Washington, DC: U.S. Congress, Government Printing Office; 1987; (Health Technology Case Study 38), OTA-HCS-38.
9. Sexton M, Hebel JR. A clinical trial of change in maternal smoking and its effect on birth weight. *JAMA* 1984;251:911-5.
10. Windsor RA, Cutter G, Morris J, et al. The effectiveness of smoking cessation methods for smokers in public health maternity clinics: a randomized trial. *Am J Public Health* 1985;75:1389-92.
11. Ershoff DH, Aaronson NK, Danaher BG, Wasserman FW. Behavioral, health, and cost outcomes of an HMO-based perinatal health education program. *Public Health Rep* 1983;98:536-47.
12. MacArthur C, Newton JR, Knox EG. Effect of anti-smoking health education on infant size at birth: a randomized controlled trial. *Brit J Obstet Gynaecol* 1987; 94:295-300.

13. Lilley J, Forster DP. A randomized controlled trial of individual counseling of smokers in pregnancy. *Public Health* 1986;100:309-15.
14. Donovan JW. Randomized controlled trial of anti-smoking advice in pregnancy. *Brit J Prev Soc Med* 1977;31:6-12.
15. Aaronson NK, Ershoff DH, Danahar BG. Smoking cessation in pregnancy: a self-help approach. *Addict Behav* 1985;10:103-8.
16. Williamson DF, Serdula MK, Kendrick JS, Binkin NJ. Comparing the prevalence of smoking in pregnant and non-pregnant women, 1985 to 1986. *JAMA* 1989;261:70-4.
17. U.S. Department of Health and Human Services. Reducing the health consequences of smoking: 25 years of progress. A report of the Surgeon General. Washington, DC: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 1989; DHHS publication no. (CDC)89-8411.
18. Kleinman JC, Madans JH. The effects of maternal smoking, physical stature, and educational attainment on the incidence of low birth weight. *Am J Epidemiol* 1985;121:843-5.
19. Doubilet P, Weinstein MC, McNeil BJ. Use and misuse of the term "cost effective" in medicine. *New Engl J Med* 1986;314:253-6.
20. Prager K, Malin H, Spiegler D, Van Motts P, Placek PJ. Smoking and drinking behavior before and during pregnancy of married mothers of live-born infants and stillborn infants. *Public Health Rep* 1984;99:117-27.
21. Windsor RA, Warner KE, Cutter GR. A cost-effectiveness analysis of self-help smoking cessation methods for pregnant women. *Public Health Rep* 1988;103:83-8.
22. Ershoff DH, Mullen PD, Quinn VP. A randomized trial of a socialized self-help smoking cessation program for pregnant women in an HMO. *Am J Public Health* 1989;79:182-7.
23. Walter SD. Calculation of attributable risks from epidemiological data. *Int J Epidemiol* 1978;7:175-82.
24. National Center for Health Statistics. Perinatal mortality in the United States: 1981-1985. Hyattsville, Maryland: National Center for Health Statistics; 1989; DHHS publication no. (PHS)89-1120. (Monthly vital statistics report; volume 37; supplement 10).
25. Alan Guttmacher Institute. Financing maternity care in the United States. New York: Alan Guttmacher Institute; 1987.
26. Korenbrot CC. Risk reduction in pregnancies of low-income women: comprehensive prenatal care through the OB Access Project. *Mobius* 1984;4:34-43.
27. U.S. Congress, Office of Technology Assessment. Healthy children: investing in the future. Washington, DC: Government Printing Office; 1987; OTA-H-345.
28. National Center for Health Statistics. Annual summary of births, marriages, divorces, and deaths: United States, 1986. Hyattsville, Maryland: National Center for Health Statistics; 1987; DHHS publication no. (PHS) 87-1120. (Monthly vital statistics report; volume 35; no. 13).
29. Massachusetts Department of Public Health. Cost-benefit analysis of newborn screening for metabolic disorders. *N Engl J Med* 1974;291:1414-16.
30. Layde PM, Von Allmen SD, Oakley GP. Congenital hypothyroidism control programs: cost-benefit analysis. *JAMA* 1979;241:2290-2.
31. Layde PM, Von Allmen SD, Oakley GP. Maternal serum alpha-fetoprotein screening: a cost-benefit analysis. *Am J Public Health* 1979;69:566-73.
32. Hagard S, Carter FA. Preventing the birth of infants with Down's syndrome: a cost-benefit analysis. *Brit Med J* 1976;1:753-6.
33. Institute of Medicine. Preventing low birthweight. Washington, DC: National Academy Press; 1985.
34. Boyle MH, Torrance GW, Sinclair JC, Horwood SP. Economic evaluation of neonatal intensive care of very low birth-weight infants. *N Engl J Med* 1983;308:1330-7.
35. Ingram DD, Makuc D, Keinman JC. National and state trends in use of prenatal care, 1970-83. *Am J Publ Health* 1986;76:415-23.
36. Malloy MH, Kleinman JC, Land GH, Schramm WF. The association of smoking with age and cause of infant death. *Am J Epidemiol* 1988;128:46-55.
37. Nelson KB, Ellenberg JH. Predictors of low and very low birth weight and the relation of these to cerebral palsy. *JAMA* 1985;254:1473-9.
38. Oster G, Delea TE, Colditz GA. Maternal smoking during pregnancy and expenditures on neonatal health care. *Am J Prev Med* 1988;4:216-9.
39. Oster G, Colditz GA, Kelly NL. The economic costs of smoking and the benefits of quitting for individual smokers. *Prev Med* 1984;13:377-89.

Chairman STARK. If there are no further comments, the hearing is adjourned.

[Whereupon, at 2:10 p.m., the committee was adjourned, to reconvene at 10 a.m., Friday, October 22, 1993.]

PRESIDENT'S HEALTH CARE REFORM PROPOSALS: IMPACT ON PROVIDERS AND CONSUMERS

FRIDAY, OCTOBER 22, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:05 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

Chairman STARK. Good morning. Today Subcommittee on Health continues its series of hearings on the administration's health care reform proposal with testimony from various groups representing health care providers. The President's health care reform plan represents a bold and comprehensive response to one of the Nation's most pressing problems. The plan embraces the critical goals of universal health coverage and cost containment goals we have been seeking for many years.

The plan is both complex and far-reaching dealing with just about every issue of health care. Because of this it is not surprising that the plan has drawn mixed reactions. It would be impossible for every group to agree with every aspect and nuance of the proposed plan.

Each of these issues will have to be addressed and resolved as we proceed through the legislative process. We hope these hearings will provide an opportunity for individuals and organizations to comment on what they feel are the strengths and weaknesses of the President's plan. We would also encourage comments on various alternatives to the President's health care reform plan.

Before proceeding, I will recognize my distinguished colleague, Dr. McDermott, for any comments he may have, and then I will introduce our first panel. It includes three witnesses representing hospital groups. I want to welcome Larry Gage, the president of the National Association of Public Hospitals; Ron Hunter, a member of the National Rural Health Association; and from my hometown, Mr. Dauner, who is the chief executive officer of the California Association of Hospitals and Health Systems. Welcome to the committee.

As for all the witnesses today, the full written statements will be a part of the record of this hearing. In addition I would like to ask all witnesses to submit or limit their oral statements to approximately 5 minutes. You can expand on your testimony or summarize

it for us. We will then explore with you the particular issues of interest of the members of the committee.

You may proceed in the order you were introduced. Mr. Gage.

STATEMENT OF LARRY S. GAGE, PRESIDENT, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

Mr. GAGE. Thank you very much, Mr. Chairman and members of the subcommittee. I am Larry Gage, the president of the National Association of Public Hospitals. Our members include over 100 of America's metropolitan area safety net hospitals. These 100 institutions taken together comprise America's most important health and hospital system.

With combined revenues of almost \$16 billion these hospitals provide over 71 percent of their services to Medicaid and low income uninsured and underinsured patients. In other words, these hospitals already serve as national health insurance by default in most of our Nation's urban areas. At the same time they train a substantial portion of our Nation's doctors, nurses and other health professionals and often serve as the only provider of many costly, specialized services such as trauma care, burn care, neonatal intensive care, high risk pregnancy services, and emergency psychiatric care.

I am pleased to have this opportunity to testify before the Committee on National Health Reform. In addition to commenting on the President's health reform proposals, my prepared testimony today provides the committee with an update on the situation of urban public hospitals. In summary, the burden on such hospitals has continued to worsen in recent years, for a variety of reasons. These include persistent State and local budget shortfalls—escalating Federal and State curbs on Medicaid eligibility and spending—continuing increases in the number of uninsured and underinsured—and an increasing inability or unwillingness even prior to health reform of many providers to shift uncompensated costs to privately insured patients. Let me illustrate with just one of the points made in my prepared testimony.

In 1991, 47 percent of over 17 million outpatient and emergency room visits to NAPH member hospitals were not covered, even by Medicaid. Thirty percent of all discharges and 27 percent of all inpatient days were also completely unsponsored.

For this reason alone, NAPH believes that the enactment of universal health reform in this session of Congress is essential. We also believe that President Bill Clinton has offered Americans our best opportunity in over half a century to join the family of civilized nations that make adequate health care a basic right of citizenship.

We believe that President Clinton's proposal is an excellent foundation for achieving health reform, one which meets most of the principles NAPH has laid out in the past before this committee as a prerequisite to our support for any plan.

We believe a single payer system would also meet most of those principles as well as some of the other plans before Congress. At the same time we do have a number of concerns about the Clinton plan insofar as we understand it to date.

While a more detailed analysis must await the release of the legislation itself, we would like to suggest a number of issues and questions for you to consider when the plan is finally submitted to Congress. However, before doing so, let me make clear that we raise these concerns from a position of support and encouragement, not opposition or any desire to obstruct. NAPH's goal, like that of the President and many members of this committee, will be the earliest possible enactment of comprehensive national health reform.

Based on our preliminary reading of the summary that has been provided of the President's plan, NAPH's primary concerns are as follows:

First, NAPH is concerned about the provision and funding of services for many individuals we currently serve who may not be eligible, or who may face significant barriers to enrollment, under the President's plan.

Second, health reform must not be financed through elimination or substantial reduction in disproportionate share hospital payments unless other protections and payments are substituted for the highest volume providers of care to our most vulnerable populations. We believe that there will be a significant impact on safety net hospitals in inner cities of serving these patients, even if they are insured.

Third, we are concerned that the benefit package may leave some costs uncovered for urban residents who suffer from alcoholism, drug abuse or mental illness.

Fourth, with respect to plan administration, NAPH is especially concerned that hospitals as well as clinics be designated essential community providers and that access for the urban and rural patients who rely on these providers be protected in various ways.

Fifth, it is essential that any major shift in the funding of medical education take into account the special needs of safety net hospitals and underserved patients.

Sixth, in order to assure adequate access and a careful transition to a new system, some urban and rural safety net providers will require assistance in gaining access to capital to rebuild.

Each of these concerns is addressed in greater detail in my prepared testimony.

I would be happy to answer any questions you may have.

Chairman STARK. Thank you.

[The prepared statement and attachment follow:]

**Statement of Larry S. Gage
President**

National Association of Public Hospitals

before the

**Subcommittee on Health
Committee on Ways & Means
U.S. House of Representatives
Washington D.C.
October 22, 1993**

Mr. Chairman, Members of the Subcommittee, I am Larry Gage, President of the National Association of Public Hospitals (NAPH). NAPH's members include over 100 of America's metropolitan area safety net hospitals. These 100 institutions (taken together) comprise America's most important health and hospital system. With combined revenues of almost \$16 billion, these hospitals provide over 71% of their services to Medicaid and low income uninsured and underinsured patients. In other words, these hospitals already serve as "national health insurance" by default in most of our nation's urban areas. At the same time, these hospitals train a substantial proportion of our nation's doctors, nurses, and other health professionals. They also often serve as the only provider of many costly, specialized services, such as trauma care, burn care, neo-natal intensive care, high risk pregnancy services, and emergency psychiatric care.

I am pleased to have this opportunity to testify before the Committee on national health reform, and in particular on the concerns of urban safety net hospitals with respect to what we have been able to learn to date of President Clinton's health plan.

Our nation's failure to provide universal health coverage, and access to care, has long been the single most glaring deficiency of our nation's health system -- one we share only with South Africa among Western nations. In the past two decades alone, there have been over a dozen major national health insurance initiatives, many offered by the members of this Committee, as well as scores of more modest proposals. Unfortunately, each of these proposals has generated influential opposition as well, virtually paralyzing all efforts to achieve needed reform.

NAPH members believe that President Bill Clinton has offered Americans our best opportunity in over half a century to join the family of civilized nations that make adequate health care a basic right of citizenship. NAPH strongly supports President Clinton in this historic effort. NAPH members are unanimously committed to working with the President -- and with the members of this Committee -- to achieve enactment of health reform as swiftly as possible. We simply cannot afford to let this opportunity slip away, like so many others in the last 50 years.

Before commenting on the specifics of health reform, it is important to point out that the situation of these safety net providers continues to worsen. The nation's urban public hospitals continue to be burdened by multiple crises -- including persistent state and local budget shortfalls -- escalating federal and state curbs on Medicaid eligibility and spending -- continuing increases in the number of uninsured and under-insured -- and an increasing inability or unwillingness of many providers to shift uncompensated costs to privately insured patients. Let me illustrate the urgency of this situation with a few simple facts:

- **Safety net hospitals are bursting at the seams.** Such hospitals today are providing an extraordinary volume of inpatient and outpatient care. 60 NAPH member hospitals across the nation averaged over 270,000 emergency room and outpatient visits and 14,000 admissions in 1991. NAPH member hospitals totalled 17.3 million emergency and outpatient visits in 1991. NAPH members averaged an 79% occupancy rate in 1991, almost 13% greater than the average for hospitals in the 100 largest cities generally for 1990.

- **Safety net hospitals are both hospital and family doctor for the uninsured.** In 1991, 30% of all discharges and 27% of all inpatient days were not sponsored -- even by Medicaid -- in NAPH member hospitals; 47% of all outpatient and emergency room visits were also uninsured.

- **Safety net hospitals are uniquely reliant on governmental funding sources.** Just 12% of the gross revenues of safety net hospitals were derived from private insurance and 16% from Medicare in 1991, while 71% were attributable to Medicaid and "self pay" patients. Average gross revenues at NAPH member hospitals were \$91.7 million for Medicaid patients and \$78.5 million for "self pay" patients (who are typically uninsured and thus "financed" by direct subsidies and other mechanisms such as Medicare and Medicaid disproportionate share adjustments).

- **Emergency and clinic patients are waiting longer to see doctors or be admitted.** 59 NAPH member hospitals reported periodic waits by emergency department patients of 12 hours or more for admission.

- **The many community-wide services provided by safety net hospitals are in danger of deterioration as well.** Trauma centers, high risk obstetric units, emergency psychiatric units, emergency drug abuse treatment programs, burn centers, neonatal intensive care units -- all are overflowing, at a time when state and local budget crises often require reductions, not increases, in funding.

In short, while Congress debates how to provide access to care, the nation's Safety Net hospitals are providing that care now, and they are providing it to more and sicker people than at any other time in our nation's history. For all of these reasons, enactment of health reform must now be our most important domestic policy priority.

NAPH believes that President Clinton's proposal is an excellent foundation for achieving health reform -- one which meets most of the principles NAPH has laid out in the past in testimony before this Committee as a prerequisite to our support for any plan. While other proposals -- such as a broad-based single payer system -- could also possibly satisfy NAPH's principles, we find much to admire in the President's plan, including:

- its commitment to universal and mandatory coverage,
- its commitment to prevention and primary care in the context of a generous uniform benefit package,
- its proposal to community rate premiums for all, as well as to adjust premiums to reflect such factors as health and income status,
- its willingness to subsidize premiums for low income individuals and small businesses, and
- its apparent willingness to pay attention to the special access and infrastructure needs of providers in underserved areas and academic health centers.

At the same time, NAPH does have a number of concerns about the Clinton plan, at least insofar as we understand it to date. While a more detailed analysis must await the release of the legislation itself, we would like to suggest a number of issues and questions for

you to consider when the plan is finally submitted to Congress. However, before doing so, let me make clear that we raise these concerns from a position of support and encouragement, not opposition or any desire to obstruct. NAPH's goal, like that of the President and many members of this Committee, will be the earliest possible enactment of comprehensive national health reform.

Based on our preliminary reading of the summary outline that has been provided of the President's plan, NAPH's primary concerns are in the following areas:

- the treatment of certain populations excluded under the plan, such as illegal immigrants and prisoners,
- the possibility that the President's plan may call for the elimination or reduction of Medicare and Medicaid disproportionate share hospital adjustments, which finance a broad range of essential services in many underserved areas,
- the extent to which hospitals will be included in the definition of "essential community provider" under the plan, and the level and scope of support for such providers under a system of "managed competition,"
- the impact of health reform on the ability of essential safety net hospitals to obtain the capital they need to rebuild their infrastructure and assure continued access in many urban and rural areas, and
- the impact on safety net providers of the dramatic changes proposed for our nation's medical education system.

The remainder of my prepared testimony will briefly describe our questions and concerns in each of these areas.

1. NAPH IS CONCERNED ABOUT THE PROVISION AND FUNDING OF SERVICES FOR MANY INDIVIDUALS WE CURRENTLY SERVE WHO MAY NOT BE ELIGIBLE — OR WHO MAY FACE SIGNIFICANT BARRIERS TO ENROLLMENT — UNDER THE PRESIDENT'S PLAN.

One of NAPH's most important principles is that national health reform must be nothing less than universal and mandatory for all residents. While the President's plan has expressed the goal of universality, and appears to be mandatory for those who are eligible, NAPH is especially concerned that there are certain populations who will continue to fall through the cracks — either intentionally or unintentionally — and that there are other potential barriers to enrollment that, if not adequately understood and addressed, will have the same effect as being ineligible for coverage in the first place.

Two populations likely to be excluded from coverage that have generated considerable discussion to date are illegal immigrants and prisoners. NAPH members and other urban public hospitals serve a very substantially disproportionate number of both populations and will be especially hard hit if they remain wholly outside the system.

With respect to illegal immigrants, the vast majority of health care currently accessible to this population is in urban and rural safety net hospitals and clinics. This care is funded by a precarious patchwork of federal, state and local funding, augmented by cost shifting wherever possible. Recent federal programs such as SLIAG, which was targeted at legal (not illegal) immigrants, have in the past been able to pay for some of these services. However, most such funding has now been reduced or terminated, and House efforts this summer to add more money to the budget reconciliation bill failed. Unless either coverage or funding is made available in health reform, the potential exists for the situation of the population to become far worse. With the expressed goal of "converting" Medicaid and other current revenue sources into premium income for those populations who will receive coverage, it is likely that there will be far less ability in the future even than there is in

already inadequately funded system today to pay for the care that will continue to be needed by this large population. We cannot make illegal immigrants -- or their health needs -- simply disappear by refusing to cover them under health reform. We must make some sort of provision for their care if we are to have a truly unified system.

With respect to prisoners, the issue is equally complex. Prisoners are today excluded from Medicaid coverage and denied many other rights. Their care is sometimes paid for by the criminal justice system that incarcerated them, sometimes by state or local governments through other means, and sometimes the cost of their care is simply absorbed by the public hospital that treats them. Because it is an unfortunate fact that many prisoners today come from segments of the population that had not previously been eligible for health coverage, the problem in the past has perhaps been less obvious and less troubling than it will be after health reform. In the future, however, all prisoners who are legal residents will theoretically have been eligible for coverage prior to their incarceration, and will again become eligible following their discharge. And while safety, security and the needs of the criminal justice system require simplicity in any health system, there is no logic to maintaining prisoners outside the new nationwide system if our goals are universality, cost containment through prevention and earlier treatment, and the broadest possible sharing of risk. While mainstreaming prisoners in alliances and plans may be impractical, clearly the entire system will benefit if targeted plans, perhaps backed by a nationwide risk pool, can be developed for prisoners.

In addition to immigrants and prisoners, NAPH is also concerned about other populations that may fall through the gaps or be unable or unwilling to enroll under health reform even if eligible. These populations include the homeless and the deinstitutionalized mentally ill.

As our experience with Medicaid demonstrates, there may be other significant barriers to enrollment even for many individuals who may otherwise be eligible -- especially in inner cities and isolated rural areas. In fact, given the complexity of the system and the need for cost sharing by all but the poorest enrollees, it is virtually guaranteed that many people will simply not sign up for a health plan, even if it is considered mandatory. Rather, they will present themselves to providers in the future as they do today -- sick or injured, addicted or mentally ill, homeless, often unable to provide us with basic information about themselves. Our experience also tells us that some inner city residents will actually sign up for multiple plans, either inadvertently or intentionally, or may conceal their previous enrollment in order to obtain care at a more convenient or familiar location. For these reasons, it is therefore imperative that the eligibility process be kept as simple as possible, that the additional costs to providers of treating and enrolling certain populations be taken into account, that providers must be able to rely on the presumptive eligibility of any individual who shows up in their emergency room, that careful outreach and patient education be provided, and that new systems include maximum protections against patient misunderstanding or abuse.

2. HEALTH REFORM MUST NOT BE FINANCED THROUGH ELIMINATION OR SUBSTANTIAL REDUCTION IN DISPROPORTIONATE SHARE HOSPITAL PAYMENTS UNLESS OTHER PROTECTIONS AND PAYMENTS ARE SUBSTITUTED FOR THE HIGHEST VOLUME PROVIDERS OF CARE TO THE POOR.

NAPH strongly supports a broad array of financing mechanisms for universal health coverage, including taxes on excess employee health coverage, so-called "sin taxes" on alcohol and tobacco, sliding scale cost sharing for higher income insured individuals, and increased Medicare cost sharing. We would also support a tax cap on the deductibility of premiums by both corporations and individuals.

NAPH's most serious concern in the areas of financing has to do with the apparent proposal to finance a substantial part of health reform through Medicare and Medicaid reductions generally, and through elimination of the so-called "disproportionate share hospital" (DSH) adjustments in particular. The DSH adjustments -- which this Committee

has played a major role in enacting and improving over the years -- have been of great importance in helping safety net hospitals provide the broad range of additional services needed by low income patients and urban (and remote rural) communities.

With respect to Medicare, since the Medicare program will remain largely outside of health reform, we believe the Medicare DSH adjustment should remain intact. We further recommend that Medicare DSH payments be strengthened for the very highest volume DSH providers (especially if there is an elimination or substantial reduction in Medicare graduate medical education funding, as is also proposed).

With respect to Medicaid, NAPH acknowledges that there have been numerous instances where states have used DSH funds for other than their intended purpose, and that with the phase-in of universal coverage this adjustment is unlikely to be preserved in its current form. However, it is important to point out that there are also many states which have not treated Medicaid DSH adjustments as a scam or a new form of revenue sharing -- which have used the adjustment as it was intended to be used, to fund substantial additional programs and services to Medicaid recipients and the uninsured poor.

Even if Medicaid DSH is phased out, we therefore believe that many residual community-wide public health and social services will continue to be needed even after most uninsured Americans have been provided some form of health coverage. Such services will range from emergency "standby" services such as trauma centers, burn centers, neonatal intensive care, and the like, to public health and social services that will still be needed by low income patients. For these reasons, as an integral part of health reform, NAPH strongly proposes that a residual payment adjustment be developed that would be carefully targeted on safety net hospitals and other facilities (such as community health centers) that will continue even under a new national health plan to serve vulnerable populations and provide essential community-wide services.

3. THOUGH ADEQUATELY COMPREHENSIVE IN MOST RESPECTS, THE PROPOSED BENEFIT PACKAGE WILL RESULT IN MANY UNCOVERED COSTS FOR SOME URBAN RESIDENTS WHO SUFFER FROM ALCOHOLISM, DRUG ABUSE OR MENTAL ILLNESS.

NAPH is please that the basic benefit package provides an **emphasis on (and in most cases, first dollar coverage for) primary and preventive care.** We also agree that it appears generous and adequate in most cases.

Our two major concerns with the contents of the benefit package are with the proposed limitations on mental health and substance abuse benefits. We are extremely concerned that, while these limitations may make good policy sense for healthy, educated, employed middle class Americans, they fail to address the much greater needs of many residents of our nations inner cities. For many individuals, these diseases are primary, not secondary, diagnoses, and substantial barriers to effective functioning. Left untreated, they have substantial implications for the quality of life of all urban residents, significantly increasing (for example) the likelihood of crime and violence in our nation's inner cities.

NAPH is also concerned with reports that some categories among currently eligible Medicaid populations -- and especially poor women and children who are eligible for Medicaid but not AFDC or SSI payments -- may lose many of the additional benefits they now receive.

4. WITH RESPECT TO PLAN ADMINISTRATION, NAPH IS ESPECIALLY CONCERNED THAT HOSPITALS AS WELL AS CLINICS BE DESIGNATED ESSENTIAL COMMUNITY PROVIDERS AND THAT ACCESS FOR THE URBAN AND RURAL PATIENTS WHO RELY ON THESE PROVIDERS BE PROTECTED IN VARIOUS WAYS.

NAPH accepts the concept of managed competition in principal and believes it should be given an opportunity to work wherever feasible. However, based on our extensive experience serving the uninsured, we are concerned that managed competition as described in the literature to date may be less effective in some areas, including inner cities and isolated rural areas. We believe this to be the case for several reasons, including the lack of a sufficient number and variety of providers to guarantee access and choice even for individuals who have been issued their "card", and the checkered history of efforts to introduce competitive models to such areas (such as the California PHP scandals of the early 1970s and the Florida scandals of the 1980s).

Of particular concern is the possibility of adverse selection and "targeted marketing" by some plans -- cream-skimming, if you will -- that will leave the sickest and the poorest to enroll in "public plans". NAPH believes that there must be substantial safeguards, including mandatory open enrollment, limitations on advertising, and mandatory random assignment of "high risk" patients. Both tough rules and strict enforcement -- including criminal penalties -- must be included.

It must further be recognized, in implementing "managed competition", that the playing field is not currently level for either providers or patients -- especially in the inner cities and remote rural areas. To be equitable, and to guarantee access for patients in such areas to the broadest range of health and social services, a plan must ensure that all safety net providers (including health centers as well as public hospitals) are given an equal opportunity to develop and participate in competitive plans.

In that regard, it is apparently the intention of the Administration to include in its plan the designation of certain providers as "essential community providers" (ECP), and to give additional support and assistance to the providers so designated (including the guarantee that they will be paid for services rendered to enrollees of all plans in underserved areas). NAPH believes it is essential that any definition of ECP include hospitals as well as clinics and other providers. This is an area in which we have worked closely for many months with the Rural Health Association, the National Association of Community Health Centers, and other groups, and in which there is complete agreement. For your information, I have attached to my testimony a copy of a position paper provided to the Administration earlier this year on this subject.

In addition, NAPH applauds the concept of a "risk adjusted" premium for plans to take into account the special needs of individuals with more serious illnesses, injuries, conditions, or personal situations (including income status). However, we are concerned that the development of such an adjustment may be complex and take longer than envisioned, and that many alliances and plans may well become fully operational well before such an adjustment is in place. In addition, we are concerned that the President appears to propose only that a risk adjustment factor be added to plan premiums, with no additional requirements or assurances that "risk-adjusted" payments also be made to those providers who will treat disproportionate numbers of those patients determined to be at risk of greater needs and higher costs.

5. IT IS ESSENTIAL THAT ANY MAJOR SHIFT IN THE FUNDING OF MEDICAL EDUCATION TAKE INTO ACCOUNT THE SPECIAL NEEDS OF SAFETY NET HOSPITALS AND UNDERSERVED PATIENTS.

NAPH strongly supports the need to develop more rational and broad-based funding mechanisms for medical education, and to shift our emphasis in medical education (as well as in patient care) away from specialization and towards primary care and prevention.

Because most NAPH member hospitals are major teaching hospitals, and rely on their medical education programs for both education and patient care, we have several concerns with what we perceive to be the President's proposal, as follows:

- Will major urban public teaching hospitals be eligible to be designated academic health science centers or "affiliated hospitals" of such centers?
- With the reduction in specialty residencies, who will be responsible for allocating residencies, and will the criteria include any reference to the importance of patient care as well as educational needs?
- In the shift away from specialty residencies, will any attention be given to the fact that there are still many parts of the country -- such as inner cities and remote rural areas -- where there are severe shortages in many medical specialties?
- Who will be responsible, within an academic health center, for allocating the proposed medical education funding and ensuring an equitable apportionment among all major components of the center?
- What impact will health reform have on the training of allied health professionals and on the ability to improve the proportion of minorities in all health professions?
- How, and over what period of time, will this new system be phased in, and what transitional funding will be available?

6. IN ORDER TO ASSURE ADEQUATE ACCESS AND A CAREFUL TRANSITION TO A NEW SYSTEM, SOME URBAN AND RURAL SAFETY NET PROVIDERS WILL REQUIRE ASSISTANCE IN GAINING ACCESS TO CAPITAL TO REBUILD THEIR INFRASTRUCTURE AND DEVELOP NEW NETWORKS AND PLANS.

Many supporters of various national health reform proposals have suggested that, if reforms were enacted, there would no longer be a need for an institutional health safety net. We can only note that the same thing was said about the enactment of Medicare and Medicaid. Given the strong likelihood that future changes will continue to be incremental and piecemeal, NAPH believes that there will continue to be a strong need for the public health safety net in our nation's metropolitan areas.

We must thus be extremely careful about dislodging any current institutional funding mechanisms for public health systems in general, and safety net hospitals in particular, unless we are certain that we have a workable and fully implemented system to take their place. Moreover, we must continue to press forward with more targeted programs and reforms that support "stand by" health and social services and safety net providers.

For many reasons, even if national health insurance were adopted this year, America's safety net institutions will need continued support well into the future:

- Any new health reform system is likely to be phased in over a long period of time.
- Even with coverage, many of our current uninsured will be little better off than Medicaid patients, who today find their access restricted in many states to those "open door" hospitals and clinics who will serve them.
- It is also important to recognize that many of the current uninsured also suffer from a variety of health and social problems very different from those of middle America -- AIDS, drug abuse, tuberculosis, and teenage pregnancies are often augmented by homelessness, joblessness, and lack of education; while no health care provider can fully cope with all of these problems, our urban safety net hospitals are the only ones even trying to do so today.

- In addition, we must recognize that even for insured individuals today, with the dramatic cost containment efforts already being imposed by both public and private payers, many expensive and unprofitable "standby" services (such as trauma, burn care, and neonatal intensive care) are also far more likely to be available in safety net hospitals.
- Finally, many safety net hospitals are simply located in the geographic areas where most of our uninsured Americans reside -- areas which, even if national health coverage were fully implemented, most other health care providers will continue to be unwilling or unable to serve.

For all of these reasons, essential urban and rural safety net hospitals are likely to face a substantial need for assistance under health reform in obtaining adequate capital to rebuild and equip our nation's health infrastructure. A 1993 NAPH study estimates that there are at least \$15 billion in unmet capital needs among these essential urban providers. Yet these hospitals also face significant barriers in obtaining access to capital, as well as in their ability to repay incurred debts entirely from patient care revenues. In order to meet these needs, a new Federal capital financing initiative is clearly needed. NAPH has assisted with the drafting of a major new urban/rural capital financing initiative that was first introduced in 1992, and has been reintroduced this year by Chairman Pete Stark in the House, and by Senators Thomas Daschle, John Breaux and Max Baucus in the Senate. While its cost to the federal government would be only \$1 billion per year, this bill would create federal-state-local and public-private partnerships to finance up to \$15 billion in capital improvements for safety net hospitals, through loan guarantees, interest rate subsidies and grants to meet both general and specific safety net capital needs.

In addition to capital needs, there are other areas in which infrastructure and "enabling services" must be funded to ensure a smooth transition to universal coverage. For example, it is important that funding be made available to improve the ability of urban and rural safety net providers to develop and finance regional provider networks that include a full range of services, including ambulatory and preventive care in addition to acute inpatient care, and to participate as effectively as possible in managed care programs and initiatives. It is also essential that the many health and social programs and services currently provided by public hospitals and public health departments be continued, and that the implementation of health reform not be permitted to diminish or reduce support for these programs and services.

Many of these programs and services will continue to be needed and provided outside of even the most comprehensive of benefit packages, which brings me to the final point I want to make to the Committee today: it is clear that there are many parts of our health system today that are not functioning properly, that need to be restructured or reformed. But we fear that the Clinton plan, while addressing all of these necessary reforms, may be endangering some parts of the current system that are among its most important and compassionate elements. Because we have relied so heavily on institutions to fill in the huge gaps in our system, we also have a system today in which many providers have long been ready, willing and able to serve as a "provider of last resort" -- to keep their doors open and their services accessible to all persons, whether or not those services are paid for under any health plan.

It is essential that this Committee at least be aware of the potential danger, as we move towards health reform, of losing this concept of a health safety net, of the "provider of last resort," in our system. If the various funding and administrative reforms in the President's proposal are fully implemented, there will be far fewer resources at the state or local level, and far less cost shifting available to safety net providers themselves, than in our current system. We are already seeing today the phenomenon of state and local governments reducing (or planning to reduce) their direct subsidies for safety net services, in anticipation of health reform. If the federal government is not willing to adequately support the existence of a "provider of last resort" capacity, it is highly likely that no one else will do so either, and this capacity will disappear.

In conclusion, NAPH agrees that we desperately need to enact health reform and universal coverage, and we will vigorously support the President and this Committee as you move forward to consider the proposals before you. We only ask that if reform requires you to restructure parts of the system that are currently functioning effectively -- if you have to break things that aren't necessarily broken in order to repair things that are -- that you do so only with the greatest care. In other words, we urge you to be certain that the system you reassemble is an improvement, not a step backwards, for all of our most vulnerable populations and the essential providers that serve them.

I would be pleased to answer any questions you may have at this time.

Recommendations to Task Force: Essential Community Provider Infrastructure

April 19, 1993

As America debates the future of its health care system, one imperative is clear: "essential community providers" — including safety net institutions such as community health centers and urban and rural public hospitals — are going to continue to play a vital role in health care delivery under health care reform. Federal recognition of this role will be crucial to the success of health reform for several important reasons:

- No reform plan, no matter how ambitious, can truly promise universal access for all — certain individuals will inevitably continue to fall through the cracks.
- As we have learned from Medicaid, simply making a person eligible for coverage does not guarantee convenient and equitable access to care; even for a basic package of preventive, primary and acute health services, many inner city and rural areas will continue to be geographically underserved.
- The specialized standby medical, public health and social services provided by these institutions — such as 24 hour trauma care, bilingual services, socially aware discharge planners and various other outreach programs — are rarely available in inner city or remote rural areas except through safety net providers.

Clearly, safety net community providers are not going to fade away in the foreseeable future. It is therefore essential to address their urgent infrastructure needs in the context of health system reform.

At the outset, it is important to emphasize that the infrastructure investment required is not vast or open-ended. Rather, such support can be carefully targeted on those providers that meet truly essential community needs.

Nor is it necessary to reinvent the wheel in defining these providers. Several definitions already exist in federal law, such as the Federally Qualified Health Center (FQHC), Essential Access Community Hospital (EACH), 1992 Medicaid Drug Pricing exceptions legislation, and high volume Medicare and Medicaid "disproportionate share hospital" (DSH) definitions. There are also a number of federal programs (like community and migrant health centers, maternal and child health, and family planning) that describe eligible grantees in some detail. It should be a relatively simple matter to adapt or cross-reference these definitions for the purposes of health reform legislation.

Three major infrastructure needs must be met in any health reform package if access to essential community health services is to be preserved and protected:

- Seed funding should be available to safety net institutions that are willing to restructure the health care delivery system to form community health networks to improve access to a full range of primary and preventive health services.
- Targeted capital financing assistance should be provided to rebuild and renovate.
- Explicit acknowledgment must be made of the role to be played by "essential access" safety net providers after health reform is phased in, including guarantees of a level playing field in competing for newly covered individuals in inner city and remote rural communities, and continued direct funding for special services not covered in the health reform benefit package.

Specific proposals in each of these three areas will be summarized in the balance of this memorandum.

1. Federal Support for the Development of Community Health Networks and Primary Care Capacity for Underserved Areas.

Federal seed funding is needed to promote and encourage the restructuring of health care delivery systems in underserved urban and rural areas. In particular, funding is requested for the development of regional community health networks (CHNs) centered around providers of preventive and primary care (including FQHCs and FQHC look-alikes, local public health agencies providing primary care, EACHs and public or other DSH providers serving substantial numbers of low income patients.)

The purpose of encouraging the development of CHNs will be to improve the organization and delivery of preventive and primary care services, improve access for low income patients, promote the development and training of managed care providers, better coordinate care on a regionwide basis, and reduce inappropriate or unnecessary services.

It is proposed that seed grants be made available to two different kinds of CHNs: primary care networks and full service networks. Partners in primary care CHNs should be required to meet certain minimum requirements, such as serving as FQHCs or FQHC look-alikes (except for the governing board requirement). Full service CHNs may be formed by a combination of primary care and acute care providers, including FQHCs, FQHC look-alikes, public health agencies, DSHs, EACHs, sole community hospitals and other rural providers in underserved areas.

Development grants can be used to cover such costs as planning, needs assessment, feasibility studies, recruitment and training, development of clinical and financial management and information systems, establishment of reserves as required for assumption of actuarial risks. CHN participants would also be eligible, as needed, for capital assistance under (2) below and operating assistance under (3) below.

2. Targeted Capital Funding to Rebuild and Renovate Essential Access Providers

The need to provide targeted Federal support for the nation's urban and rural safety net providers was recognized in 1992, when Senate Finance Committee members Tom Daschle and John Breaux, and House Ways & Means Health Subcommittee Chairman Pete Stark introduced the National Health Safety Net Infrastructure Act. It is important to point out that this legislation -- which was reintroduced in the Senate in March with the addition of Senator Max Baucus as a cosponsor -- is not an effort to recreate the old Hill-Burton program. Rather, it would target financing dollars and loan guarantees on a small group of narrowly-defined safety net institutions with capital needs that cannot be met through traditional financing sources.

It is proposed that providers must meet two general criteria to be eligible for assistance. First, if they are hospitals, they must qualify for Medicare or Medicaid disproportionate share adjustments, or qualify as an Essential Access Community Hospital (EACH) or rural primary care hospital under Medicare. Urban hospitals must be owned, operated or (if they are non-profit hospitals) must be at least partially financed by direct state or local subsidies. (About 200 hospitals meet this definition; if, in the alternative, all high volume public and private Medicare DSH hospitals were included, about 400 hospitals would be covered, under the definition adopted several years ago to permit certain hospitals to continue to receive Medicare Periodic Interim Payments.)

Health centers must qualify as a Federally-Qualified Health Center (FQHC) or "FQHC look-alike" under Medicaid, or meet other appropriate criteria set by the Secretary of Health and Human Services (HHS).

The need for capital infrastructure assistance varies in different parts of the country. In some areas, providers have problems gaining access to the capital markets without some form of credit enhancement such as loan guarantees. In other areas, providers can get access to the markets, but require assistance (such as interest rate subsidies) in repaying their loans. And for some providers and types of projects (especially smaller primary care or emergency projects), direct loans and grants are the best vehicle. For these reasons, it is proposed that four basic types of financing assistance be made available to eligible providers: loan guarantees, interest rate subsidies, direct loans, and direct grants.

- Loan guarantees, such as are currently available to some hospitals under the FHA Section 242 hospital mortgage insurance program, could provide federal guarantees of loan repayment to non-Federal lenders making loans to qualified providers for replacement, modernization and renovation projects. Only those projects for which the guarantee is essential to obtaining affordable financing would be funded. The Federal guarantee would reduce the risk of lending to safety net institutions, thereby bringing down the interest rate to reasonable levels. Loan guarantees will permit a substantial leveraging of federal assistance; a relatively small investment of federal dollars would dramatically increase private capital investment in essential community providers. Please note that while the FHA Section 242 program can be used as a model, certain changes would be needed; in particular, the cumbersome application and administrative process (involving both HHS and HUD), and the requirement that a provider be legally able to mortgage its facilities, have limited the utility of this program.
- Interest rate subsidies would be made available to public safety net providers where the state or local government has demonstrated a significant commitment to financing the

project through a matching contribution and to non-profit community providers with significant Federal, state or local support.

- Direct matching loans should also be provided for smaller capital projects. Non-federal sources could be required to provide matching funds for a specified percentage of the cost of the project (with a waiver available for financially-distressed providers).
- Finally, funds should be provided, on a carefully targeted basis, for direct grants to providers for emergency projects necessary to meet life safety code or similar standards to retain accreditation or certification; for projects necessary to maintain essential safety and health services such as obstetrics, perinatal, emergency and trauma, primary care, and preventive health services; for down payment on a broader capital financing plan; and for planning purposes. Financially distressed providers should have priority for the direct grants.

It is suggested that whatever funding is available for this capital financing program be divided as follows: 40% devoted to startup of a loan guarantee program, with the remainder divided roughly evenly among the other three purposes.

It is important that assistance be available under this program for both inpatient and outpatient services, albeit subject to a rigorous determination of the needs of the population to be served. The ability of a provider to take advantage of these programs should clearly carry with it certain responsibilities, which could assume various forms. For example, providers could be required to make the services of the renovated facility open and available to all residents in their territorial areas. In addition, eligible providers could be obliged to provide a substantial volume of services to low income persons or residents of underserved areas, or to continue to provide specified community health and social services. Finally, suggestions regarding the administration and financing of the proposed capital financing assistance are spelled out in greater detail in the attached bill, which incorporates a number of revisions made this year, prior to reintroduction, in response to concerns expressed by rural providers and community health centers.

3. Continued Support & Recognition of "Essential Access" Safety Net Providers

In addition to capital financing assistance and seed funding for the development of community health networks, those "essential access" safety net providers that form the health system infrastructure in urban and rural areas will also require ongoing operational support and recognition under health reform. This support and recognition should include the following:

- Safety net and essential community providers will clearly require continued and expanded operating support during the phase in of universal coverage to fund continued services for uninsured patients and broader community and public health services.
- For CHNs and other essential community providers, this support should take the form of continued and expanded operating subsidies under PHS Act authorizations, and continued implementation and expansion of cost-based reimbursement for FQHC under Medicare and Medicaid (or any successor programs).
- For "high volume" DSHs, e.g. as defined in the recent Medicaid drug pricing amendments, continuation of the disproportionate share adjustments under Medicare and Medicaid will be essential as long as significant numbers of uninsured patients continue to require their services.
- Even after health reform is fully phased in, a certain level of operating subsidies will still be required to recognize that there will always be individuals who fall through the gaps, and that there will continue to be many important public health and social services, and 24 hour "standby" services such as trauma care, provided by these institutions.
- Such continued assistance can take the form of the continued requirement of cost-based reimbursement for FQHCs and FQHC look-alikes, a targeted operating grant program for CHNs, and the implementation of a Community Service Adjustment (CSA) for DSH hospitals, which would be more narrowly focussed than current DSH payments.
- With respect to the implementation of increased coverage through health care reform, including the development of systems of managed competition, it is essential that all plans be required to pay essential providers for services provided to residents of underserved areas, and that a level playing field be created and

maintained in terms of the ability of essential community providers to create or participate in accountable health plans.

- In particular, FOHCs, CHNs, high volume DSHs and other institutions identified in this memorandum must be permitted full participation in any managed competition plans that are implemented in their area, including the ability (if relevant) to participate in the governance of health alliances, the ability to serve (and be reimbursed) as approved providers for enrolled patients under affordable health plans (AHPs) developed by others, and the ability (without undue restrictions) to develop and offer their own AHPs if desired.

Chairman STARK. Mr. Hunter.

STATEMENT OF RON V. HUNTER, MEMBER, RURAL HEALTH POLICY BOARD, NATIONAL RURAL HEALTH ASSOCIATION; AND ADMINISTRATOR, CHESTER COUNTY HOSPITAL AND NURSING CENTER, CHESTER, S.C.

Mr. HUNTER. Thank you, Mr. Chairman. My name is Ron V. Hunter, and I am administrator at Chester County Hospital and Nursing Center and I am also representing the National Rural Health Association as a member of its Rural Health Policy Board.

Chairman STARK. You will have to forgive me, but where is the Chester—

Mr. HUNTER. South Carolina. I do appreciate the opportunity to appear before the committee today to discuss health care reform. While the National Rural Health Association supports the need for reform, we have great concerns over the President's plan to cut \$238 billion in Medicare and Medicaid funding over the next 5 years to help finance universal access.

More than 70 percent of the Chester County Hospital population receives benefits from Medicare and Medicaid and reductions already being implemented in OBRA 1993 are threatening services in rural areas. Chester County Hospital and Nursing Center is an 82-bed hospital and a 100-bed, long-term care center.

In a community the size of Chester, a hospital is more than just a hospital. We are the center of health care delivery for an entire county of approximately 35,000 residents. Over the years we have remained viable despite challenges presented by the reimbursement system under Medicare and Medicaid programs. This situation could become critical, however, due to continuing reductions in funding as proposed by the administration.

As background, the Medicare prospective payment system has placed rural hospitals at a disadvantage to urban hospitals since 1983. Over the years PPS has reimbursed us at rates up to 40 percent lower than nearby urban hospitals. Inequities in urban-rural PPS funding were temporarily addressed by the Medicare Geographic Reclassification Board 2 years ago.

This board reclassified my hospital under the urban rate, but new regulations in effect this year do away with that classification. This change will cost my hospital in excess of \$600,000. OBRA 1993 cuts to capital and outpatient payments will cost my facility another \$200,000. The phasedown or the elimination of Medicare disproportionate share payments could eventually cost my hospital a portion or all of our current \$1 million in funding.

To bring rural hospitals to parity NRHA recommends that the disproportionate share adjustment be the same for rural hospitals as for urban hospitals. I fear a great many rural hospitals would not survive if the proposed shifting of \$238 billion from Medicare and Medicaid does indeed become a reality.

The loss of any rural hospital results in the loss of primary care physicians who are already in short supply in rural communities. The loss of a hospital to a rural community also inhibits economic development and leads to jobs lost.

While residents in our community are regularly referred to nearby regional medical centers for specialized care they do look to us,

however, for primary care needs. Having to leave our communities for even primary care would create a tremendous burden on the elderly and the poor who are covered by the Medicare and Medicaid programs.

We are concerned that health care reform not disrupt existing long-term care relationships built over decades and use State lines as arbitrary boundaries for networks. One of our partners which has for many years been our major trauma referral center is located in Charlotte, N.C.

The NRHA is concerned over the emphasis within the administration's plan and others on managed competition. Most of these plans rely on creating economies of scale from large populations that can be served in centralized locations. This model of care will not work as well in rural areas where populations are small and widely dispersed.

Rural providers need flexibility to design models of care in rural areas where large concentrated populations simply do not exist. Programs that we could draw upon to create a rural model is the EACH and RPDH programs and Montana's medical assistance facility program. Excellent regional models we could learn from include the rural Wisconsin Hospital Cooperative and the Upper Hudson Primary Care Consortium.

The NRHA requests clarification of the essential community provider language in the Clinton plan to ensure that all rural hospitals and all qualified clinics in health care professional shortage areas, not just those receiving Federal funds. I urge this committee to carefully consider the President's planned Medicaid and Medicare cuts and fully evaluate the impact across the full spectrum of urban and rural providers and consumers.

Chairman STARK. We will.

Mr. HUNTER. I urge you to weigh these considerations very carefully and consider the ramifications of reform plans on Chester, S.C., and thousands of other rural communities that make up the heartland of America. Thank you.

[The prepared statement follows:]



National Rural Health Association

OFFICERS

— Linda Denton
— President
— James Bernstein
— Vice President

— Tim Sizemore
— Treasurer

— Ross Morne
— Secretary

— Bruce Behringer
— Past President

TRUSTEES

— Harold Brown
— Raymond Coward
— Malcolm Findlater
— John Grant
— Jay Harris
— Ron Hunter
— Carol Miller
— Bernice Simmons

**Testimony of Ron V. Hunter
Administrator
Chester County Hospital and Nursing Center
on behalf of the
National Rural Health Association
before the
House Ways and Means Subcommittee on Health**

October 22, 1993

My name is Ron V. Hunter and I am administrator of Chester County Hospital and Nursing Center. I am also representing the National Rural Health Association as a member of its Rural Health Policy Board.

I appreciate the opportunity to appear before your committee today to discuss health care reform. While the National Rural Health Association supports the need for reform, we have great concerns over the President's plan to cut \$238 billion in Medicare and Medicaid funding over the next five years to help finance universal access. More than 70 percent of our patient population receives benefits from these programs and reductions already being implemented through OBRA 1993 are threatening services in rural areas.

Serving Chester County, South Carolina

Chester County, South Carolina is a community of about 35,000 people located 45 minutes south of Charlotte, North Carolina. Our community traces its roots back to the early 1700s and has evolved over the years from an agricultural and cotton mill economy to a relatively diversified manufacturing area today.

While our economy enjoyed a relatively strong growth rate with new plant openings and expansions throughout the mid-1980s, the current recession beginning four years ago has slowed that rate of growth. The unemployment rate is approximately 12 percent, which represents about 1,800 workers actively seeking employment.

Hospital Center of Health Care

Chester County Hospital and Nursing Center opened in 1952 and added a long-term care center in 1968. The entire facility is county-owned, but has maintained a tradition of self-sufficiency.

We have a medical staff of 24 physicians, including family practice, internal medicine, obstetrics and gynecology, orthopaedic surgery, ophthalmology, urology, anesthesiology, general surgery, radiology and pathology.

Our hospital has about 3,000 inpatient admissions each year, 12,000 outpatient visits and 13,000 emergency room visits. Our obstetrics department births more than 300 babies annually. More than 70 percent of our patients rely on Medicare or Medicaid benefits and another five percent are indigent.

In a community the size of Chester, a hospital is more than just a hospital. We're the center of health care delivery for an entire community, coordinating services with social services, mental health, the health department and others.

We recruit physicians to the county and provide the facilities they need for quality medical practice. We support the emergency medical system with a 24-hour physician staffed emergency room and technical expertise and back-up. We serve as the first link in an integrated, regional health care delivery system, providing primary care services as well as referral access to major medical centers.

NATIONAL HEADQUARTERS

Walter P. Pidgeon Jr.
Executive Director
301 East Armour Boulevard, Suite 420
Kansas City, Missouri 64111
Telephone (816) 756-3140
Fax (816) 756-3144

WASHINGTON OFFICE

2221 Massachusetts Avenue, N.W.
Washington, D.C. 20036
Telephone (202) 232-3553
Fax (202) 232-9044

Our hospital and nursing center is also a vital economic force in our community. We play an active role in industrial development and provide jobs for 350 people with an annual payroll of \$7 million.

Responding To Changing Environment

Over the years, we have responded to the changing health care climate, particularly rapid changes taking place in the early 1980s and continuing today. The major elements of our strategy of recent years have included:

- . "Right sizing" our facility. -- During the past five years, we have reduced our inpatient capacity from 119 to 82 beds, increased long-term care from 62 beds to 100 and added additional capacity for outpatient services. All of these changes were geared to changing utilization patterns -- shorter and fewer hospital visits, more need for long-term care and dramatic increases in outpatient care. The Medicare Prospective Payment System was also a major factor in the reduction of our inpatient capacity by reducing inpatient service needs.

- . Modernization and streamlining. -- During the past several years, we have invested in our facilities to increase our overall efficiency and to modernize our 40-year-old physical plant. We are automating information processing throughout the facility and looking for efficiencies in staffing wherever possible.

- . New cost effective services. -- We have recently created a home health agency and hospice, designed to deliver care in the least expensive, most compassionate manner possible.

- . Physician recruiting. -- Our hospital has an on-going program of physician recruitment, with a primary care emphasis. We have added six primary care physicians to our staff during the past three years.

- . Regional affiliations. -- We are currently formalizing long-term working relationships with four major medical centers in our region. Through more formal affiliations, we hope to achieve greater cost efficiencies in purchasing, gain access to technical expertise and encourage cost effective referrals from primary care providers to major medical centers.

We are concerned that health care reform not disrupt existing, long-term relationships built up over decades. We also hope that reform will not use state lines as arbitrary boundaries for networks. One of our potential affiliate partners, which has for many years been our major trauma referral center, is in North Carolina.

Reimbursements Challenge Rural Health Care

Our strategies have helped us remain a viable institution, despite challenges presented by the reimbursement system under Medicare and Medicaid. These challenges are being increased by OBRA 1993 and could become critical under health care reform as currently proposed.

The Medicare Prospective Payment System has placed rural hospitals at a distinct disadvantage to urban hospitals since 1983. Despite the fact that we pay the same or higher prices for drugs and other supplies and the same or higher salaries for medical personnel, Medicare has, over the years, reimbursed us at rates up to 40 percent less than urban hospitals.

Our hospital enjoyed parity with urban hospitals for two years under the Medicare Geographic Classification Board, but lost our urban status under new rules implemented this year, with a negative impact of more than \$600,000. We applaud market basket updates favoring rural hospitals and the movement to a single, national rate under Medicare, but those measures will not make up for years of inequity.

In addition to the problems of inequity in the Prospective Payment System, we are facing greater challenges in continuing cuts in Medicare spending. OBRA 1993 extends both capital and outpatient spending reductions, which will cost our facility \$200,000 during the next year.

Rural Hospitals Medicare/Medicaid Dependent

Medicare and Medicaid programs are crucial to us because approximately 70 percent of our patients receive either Medicare or Medicaid benefits, reflecting a population that is disproportionately older and poorer. This percentage makes us dependent on these programs and vulnerable to any changes in reimbursements, including the President's plan to reduce disproportionate share Medicare and Medicaid programs. We are also concerned over the disparity between urban and rural criteria for qualifying for disproportionate share, with urban hospitals granted a lower threshold than rural providers.

While we are experiencing continuing limits on our reimbursements, government regulatory requirements are driving up our costs. For example, in our long-term care center, we have two registered nurses who do nothing but review patient charts for compliance with OBRA. In our lab, one technician works full-time meeting CLIA requirements.

Alarm Over Further Medicare and Medicaid Cuts

Our dependence on Medicare and Medicaid programs causes us great alarm as we review the President's Health Care Reform Plan. The viability of a great many rural hospitals would be threatened if the proposal for shifting \$238 billion from Medicare and Medicaid should become a reality.

Rural hospitals might gain some additional payments under newly covered individuals with universal access, but the massive loss of Medicare and Medicaid funding would threaten their futures. Given the dependency on Medicare and Medicaid funding, rural hospitals are being asked to share too much of the cost of health care reform.

While there are often other hospitals within proximity to a rural facility, this distance creates a tremendous burden to the elderly and the poor covered by Medicare and Medicaid. The loss of any rural hospital results in the loss of primary care physicians from the community who find the practice of medicine unfulfilling professionally or financially in a community without a primary care hospital. The loss of a hospital to a rural community also greatly inhibits industrial development and leads to jobs loss.

Health Care Reform Supported

There are, of course, certain elements of President Clinton's plan and others that are admirable and deserve serious consideration — universal access, federal leadership, state and local self-determination, community development, consumer choice, financing incentives, education and training and quality and efficiency. We also support graduate medical education at rural ambulatory sites to help train primary care providers.

All of these objectives address reform needs, but it's like rearranging the deck chairs on the Titanic. If we make these changes to address rural issues, but pull the rug out from under rural hospitals struggling under an already poorly funded reimbursement system, the battle for reform will be lost.

Rural Model Needed for Managed Care

We are also concerned over the emphasis within the administration's plan and with others on managed care and managed competition. Most of these plans rely on creating economies of scale from large populations that can be served in centralized locations. This model of care will not work in rural areas where populations are small and widely disbursed. Rural providers need more flexibility to design models of care in rural areas where large, concentrated populations do not exist.

For example, the Essential Access Community Hospital (EACH), Rural Primary Care Hospital (RPCH) and Medical Assistance Facility (MAF) programs provide excellent federal examples of networks, while the Rural Wisconsin Hospital Cooperative and Upper Hudson Primary Care Consortium provide valuable regional models. We should draw from the best of these networks in creating the best model for rural America.

Our hospital is looking to participate in several managed care delivery networks, but we are having to go slowly. The management expertise with managed care in rural areas and in the South in general is limited. We have to be careful because if we join the wrong network with poor management skills and they make mistakes we don't have margins to absorb those mistakes.

In that regard, we would suggest that rural hospitals be treated as essential providers similar to community and migrant health centers under the President's plan. This approach would provide a five-year window for alliances to determine the appropriate role for rural hospitals in a managed competition environment.

Preserve Rural Health Care

My hope is President Clinton's plan for Health Care Reform is not intended to damage rural hospitals. My fear is that unless the \$238 billion cut in Medicare and Medicaid payments is not changed, health care reform will result in the loss of health care resources in rural America and reduced availability of primary care services already in short supply.

I would implore this committee to consider carefully the President's planned Medicare and Medicaid cuts and fully evaluate the impact across the full spectrum, both urban and rural, providers and consumers. It is admirable to want to provide universal coverage, but you cannot stretch Medicare and Medicaid dollars any further without severe repercussions.

You cannot expect providers such as Chester County Hospital and Nursing Center to share any greater financial burden and continue to be the hub of health care in our community. We play a vital role in our community and with your support we can continue to meet local needs for quality, cost effective care in a growing, safe community.

I urge you to weigh these considerations very carefully and consider the ramifications of reform plans on Chester, South Carolina and thousands of other rural communities that make up the heartland of America.

#

Chairman STARK. How big is Chester County?

Mr. HUNTER. The county is approximately 35,000. The city about 16,000. We have an 82-bed hospital and a 100-bed, long-term care center.

Chairman STARK. How many more hospitals are in the county?

Mr. HUNTER. We are the only hospital, the only nursing home.

Chairman STARK. There are some hospitals like that in California, but there are some big ones, too. Tell us about California's problems, Mr. Dauner.

STATEMENT OF C. DUANE DAUNER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, CALIFORNIA ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS

Mr. DAUNER. Thank you, Mr. Chairman. I am Duane Dauner, president of the association representing the hospitals and health systems in California. We are pleased to be here before you today to discuss the President's health reform proposal.

California hospitals support the goals that the President has outlined. We, for many years, have subscribed to universal access to a standard benefit package which is affordable. We also support the President's intent to build on the existing strengths of the system, but to restructure the delivery side of the equation to make it more efficient. Our values, conditions and vision for health reform are attached to our written statement.

We believe that the concept of managed competition is valid if it is based upon compatible and congruent incentives which cover all parties in the health care equation. If it leaves some out we believe that it will fail. The fundamental issue facing us is are we going to move to a rate regulation oriented model or are we going to move to a model which is tailored around incentives to change behavior.

Over the long term, either one might prove to be successful. This last summer a few individuals from California toured the nations of Great Britain, Sweden, Germany and Canada and those countries have variations of single payer plans and they are having the same kinds of problems as we are, and, in fact, they are trying to find ways to inject incentives into their systems so that they can modify behavior.

If we move to managed competition among fully integrated capitated paid plans, I believe that it can be structured so that we will achieve economic discipline and predictability; that it will equitably spread the risk and allow choice among individuals that they can choose within plans. They can also have the option to go outside those plans and pay for it.

With respect to the President's proposal, we believe there are 4 or 5 issues that deserve special mention that create concerns. First, the Medicare and Medicaid cuts, we believe, are unrealistic and the entitlement caps that are created probably don't respond to the transitory nature of change.

Savings will not be accrued up front and as long as Medicare is kept outside of the system the incentives for Medicare will be different than Medicaid, and it is highly unlikely—

Chairman STARK. Which entitlement caps are you referring to?

Mr. DAUNER. The proposal itself. If you read what has been released in the last couple of days from the administration, they intend for entitlement caps to be imposed more along the lines that had been discussed in previous settings than we had originally anticipated when we read the document. I think there is an intent that there be a fixed amount of money made available.

Chairman STARK. On Medicaid—only on poor people, right?

Mr. DAUNER. I think they intend for it to apply to the private sector as well.

Chairman STARK. I didn't know it would do much for the private sector except subsidize poor people, low-income workers and small businesses. Isn't that the only Federal involvement there? I want you to focus on what they are capping. They aren't capping the amount they are going to pay for General Motors retirees, are they?

Mr. DAUNER. If you read the 246-page document—

Chairman STARK. I have read it twice.

Mr. DAUNER [continuing]. It does appear that there is, but recent information released through yesterday indicates that there is a cap.

Chairman STARK. I understand that Ira said they were going to have a cap. As I understood, the cap is intended for subsidies and assistance to poor and low-income people. It will be an initial capped entitlement which means they will pick them out. After that amount, we have to get an appropriation for any increase. Mr. Gage knows how much success we have had in getting appropriated money for poor people out of a Republican administration.

We may do better, but under the budget constraints—are we talking about the same entitlement cap?

Mr. DAUNER. Yes. My understanding of the written document is the same as yours. The disproportionate payment share has been addressed, but hospitals that are safety net institutions cannot afford to look disproportionate share payments during this transition period. They will not be able to survive. The uninsured and illegal residents create a problem for 7 States.

California has more than half of the undocumented residents in the Nation. Arizona, New Mexico, Texas, Florida, New York and Illinois also have a substantial number of these individuals who are not covered in the plan except for the obstetric and emergency services which were enacted by Congress in 1986. Recognizing they may not be in the universal plan, it is important that a program be established to cover those individuals.

Rural communities, that issue has been addressed but they are unique and we need to make consideration for them.

Finally, the definition of health plan, it appears to us that it is insufficient and would allow for the creation of essentially storefront brokerage firms that would collect a payment—

Chairman STARK. Would a good analogy be if Prudential sold joint limited partnerships?

Mr. DAUNER. It might be—where they would take the payment and then turn around and try to ratchet down the providers with a payment. Managed care in its generic sense covers so many different views and everybody has a different opinion about what it

means that managed care will not solve the problem as it is played out today and will make the situation worse.

Mr. Chairman, in conclusion we believe that we should capture this moment that has been created and move toward universal access for the entire Nation to a standard benefit package which is affordable and we look forward to working with the committee to that end.

Chairman STARK. That capture the moment line is good. You also mentioned that managed care won't work. That is kind of heretical. Did you mean to say that?

Mr. DAUNER. Managed care which covers everything from PPOs, to EPOs, EPA's all those arrangements which are basically ratcheting down individual rates of payers trying to make doctors and hospitals jump through hoops to deliver services creates a middle layer, but doesn't change the incentives, and we don't believe that is a successful strategy for achieving access and long-term discipline.

Chairman STARK. I agree. Try this. One of you represents the overcrowded, underfunded hospitals that usually deal with the poorest of the poor and the remote-area hospitals with very scarce resources. You cover the gamut. Someone suggested the other day that managed care relative to your hospitals that have a complete continuum of care is OK at keeping the patients away from your door, but once they are in your institution managed care does nothing.

Once the patients are in your hospital and beginning a procedure, managed care has no effect. The only thing it does is keep patients away from your respective hospitals or treatment programs. Is that a fair assessment? Larry? Your patients don't have any coverage.

Mr. GAGE. I think we are suffering from semantic problems here. The management of a patient's care is often a very good thing for the patient, particularly a patient who has been denied access to some kind of health care, especially preventive and primary care.

I think what we are talking about here is perhaps termed "managed risk." It is not the managed care components of this plan or any plan that causes great concern to inner-city hospitals. It is that the goal of this program seems to be to push the actuarial risk of insuring these patients down to the provider, by limiting the payments that will be made to the provider or to health plans and forcing the provider instead of the insurer or the government to decide how to care for the patient with limited resources. So limiting the payment to the plans and to providers is what really dictates how much or how little care can be provided, because there will be very few other funding sources left in the system if this plan is enacted.

Chairman STARK. Once the patient enters Highland Hospital or Mr. Hunter's hospital, for the same procedure, each of your hospitals has a procedure for that patient. The physician would not treat that patient, I would not believe, any differently whether they get there or not may be a result of a second phone number or 1-800 number.

Mr. GAGE. I agree with you, and that is what most people call managed care today. But public systems like Contra Costa County, for example, have very comprehensive and effective managed care

systems both for Medicaid and the poor, as well as for county employees and others.

A lot of hospitals already provide extensive managed care because they have to live within Medicare DRGs, so that internally actually managed care has happened, at least should have happened in many hospitals today.

Mr. DAUNER. Could I followup on your question, Mr. Chairman?

Chairman STARK. Just an observation that somebody made that I thought sounded intriguing, but go ahead.

Mr. DAUNER. Managed care has proven that it is unsuccessful. The jury is already in on the way it is played out today. Managed care generally, once the patient enters the hospital, takes the form of external audits, and requirements for approvals for extended stay and becomes more of a bureaucratic process to try to force the patient out of the hospital.

I would venture to say that we have become experts at trying to manage the process of dealing with all of these external middle layer parties and have not concentrated on managing the care of the patients simply because that is the way the world has developed.

Chairman STARK. What I would call case management in my sort of pedestrian view of things.

Mr. HUNTER. I would like to make a comment with regard to managed competition. In my statement earlier, as I said that the plans that we have reviewed with managed competitions, they are creating economies of scale from large populations that simply do not exist in rural areas, and that is why we would propose evaluating and developing a rural model in an area where we already have some rural consortiums, for example, the rural Wisconsin hospital cooperative and to develop a good rural model of managed care that simply we don't have that experience today.

Chairman STARK. All three of you have read the plan right?

Mr. HUNTER. That is correct.

Chairman STARK. I am going to submit that the plan, as I look at it, is going to do nothing but add to the complexities that you are already dealing with and the bureaucracy, the level of bureaucracy that you face within your hospital. How do you all see that?

Mr. HUNTER. I fully agree with that.

Mr. GAGE. I think our concern about some of the elements that you are talking about, the alliances and the new structure that is going to be inserted at the regional level, at best is irrelevant to our hospitals. I think our big concern is the notion that it can apply in an underserved inner-city setting where patients will have a hard time being educated.

Chairman STARK. Some States have them already. California has a HIPC and CALPERS.

Mr. GAGE. But those are for employed, stable populations.

Chairman STARK. A HIPC is supposed to be for the uninsured according to good Governor Wilson.

Mr. GAGE. A CALPERS is not.

Chairman STARK. That is more like an alliance and the HIPC is supposed to take care of the uninsured. I will give you numbers later as to its phenomenal success. Do you know what the success of the HIPC in California is, Duane?

Mr. DAUNER. We don't have enough experience. It went into effect July 1 of this year. The HIPC is designed to cover small employers of 50 employees or fewer and we already had a program, as you know, for the uninsurables, and in CALPERS, none of those I would say are an alliance.

Chairman STARK. The HIPC has 15,000 in the first quarter of which 12,000 are merely employers switching from their present insurance to the HIPC and 3,000 of the 12 or 15 were uninsured or new to the program. At that rate I think it will take 75 years for the uninsured in California to be covered.

Mr. DAUNER. Yes. That leads to the point, I believe we need to have an employer mandate to bring in universal coverage of the employed people and then have a companion program for the others so that we achieve universal access. If we allow for it to happen on a voluntary basis I believe it will take many years.

Chairman STARK. Let me ask each of you, what I want to know, I want you to pick your poison. Assume with me for a moment that we are going to be faced with some kind of limitation on funds and resources, whether the government is going to do it or a HIPC is going to do it or an alliance is going to do it or the single payer system is going to do it. Somewhere down the line we are going to have a cost-controlled system that is somewhat more universal or more uniform than it is now or we are not going to have universal coverage.

That is, I think, something that is the sine qua non of this exercise. If you accept that it is there, and one answer could be none, but there is an existing system or procedure, and you can name brand names in this response. You can say Aetna's system or a county—or Medicare or Medicaid—is there a system that somehow negotiates reimbursement or controls reimbursement to your member institutions that you think is the least unacceptable, or in the alternative the best of any of the bad choices? Larry?

Mr. GAGE. I think, Mr. Chairman, if you are looking at a system of reimbursing hospitals, the hospitals that I represent, right now we have a system that does channel significant extra payments for uncompensated care through the vehicles of the Medicare and Medicaid disproportionate share adjustments. In some cases the Medicaid adjustments are quite large, even double and triple the size of the Medicaid payment itself.

A system short of universal coverage that spreads those payments out and makes them more rational across other payers would be, I think, the least worst. If you want a brand name, the Maryland rate review system is one I would name, again, short of a total restructuring.

Chairman STARK. David Hughes in Alameda County, he tells me he would like to just have an annual budget. He operates two public hospitals that are always full and collects very little. He is saying tell me what it is at the beginning of the year and you will run my hospital for better or worse. Give me a budget, so I know I have x dollars a month coming in and we will operate as best we can.

Mr. GAGE. That is the way major public hospitals operate in theory; but the annual budget often has caps that are artificial, based on local capacity to pay. The problem is the predictability of other funding sources and I think a budget-managed system would be

least worst for our members and I think our members would have no difficulty with Maryland's system.

Chairman STARK. Duane, for the nonmunicipal, the nonpublic hospitals in your membership what would you say is the—

Mr. DAUNER. The worst payment system is incremental strangulation where everybody who is on the payer side tries to cut back and reduce the payments made for individual services rendered. There is no economic predictability, it does not create incentives to restructure the delivery side. We need to resize the delivery system. We have too many hospitals in the Nation and in California. If all we do is just reduce the payments to everyone or try to cut back on payments to everyone, we don't create the motivation for changes to occur and resizing of the system so that we deploy the resources at the right places in the right volume.

Just simply ratcheting down everybody's payment does, in spite of its intent, generate a do-more-to-get-more mentality and that is counter to the long-term economic discipline we need.

Chairman STARK. What is the best system you know? Does it exist in Maryland?

Mr. DAUNER. The problem with Maryland is that it doesn't cover anyone else. While they did a reasonable job—it covers only the hospitals. It did a reasonable job on the hospitals.

Chairman STARK. We are just talking about hospitals.

Mr. DAUNER. But it didn't do the job in health care.

Chairman STARK. Let's be hospital-specific for a minute because for whatever reason much of the delivery system we segmented. Representing hospitals, and some, I understand, are Kaiser. They are a complete system. Others are just motels. They will take patients from anybody who brings them in and don't offer a lot of extra services. Of the systems of reimbursement and in effect budgeting or cost control, if you had to pick the least offensive, which is it?

Mr. DAUNER. The benefits, I think, would be this: Recognizing the uniqueness of our safety net hospitals and rurals for everybody else, pay them on a capitated basis within an integrated network that is responsible for delivering all the patient services to a defined population.

Chairman STARK. In other words, from what Kaiser does or from a variety of closed systems and take a capitated system for that population and distribute the budget to the hospitals and say you are on your own?

Mr. DAUNER. They would be a part of the integrated delivery network, yes.

Chairman STARK. Mr. Hunter.

Mr. HUNTER. Just a quick comment on that. Managed care is really in its infancy in the Carolinas.

Chairman STARK. About 3 percent of South Carolina is in any kind of plan, is that correct?

Mr. HUNTER. That is correct.

Chairman STARK. In my county half of the people in one county, almost 600,000, belong to one system, Kaiser.

Mr. HUNTER. What we have seen emerge over the last 1½ to 2 years is employers coming in and negotiating discounts. That cer-

tainly does nothing to control costs. It just limits our availability to cost shift.

One thing that I would like to interject, if I may, quickly is the regulatory environment on rural hospitals, and I want to go back to a comment that I made in my written statement. OBRA, for example, in the long-term care, we have a 100-bed, long-term care unit. We have two full-time RNs that do nothing with regard to patient care, only reviewing patients' charts to make sure they meet OBRA criteria.

If you look at the CLIA regulations for hospitals and go back to rural hospitals, we have one full-time laboratory technician in our small lab that does absolutely nothing but make sure that we meet CLIA criteria. To me, those are some of the things that we have to address to be able to reduce the cost of health care and not just negotiate discounts.

Chairman STARK. OK. You got a payment system that works better in South Carolina than any other. You like American family life, you like Medicare.

Mr. HUNTER. We don't have any that we like, to be honest.

Chairman STARK. I understand, but if you had to have one, which one is the easiest for you?

Mr. HUNTER. The easiest one for us is our largest employer in my part of the State, Springs Industries. Springs Industries is developing their managed care plan for their employees. This is the first plan that we have been involved with that is not coming in and negotiating discounts with us, but also working with us from the clinical standpoint in looking at that patient's chart and stay and helping us in case management uses clinical pathways to make sure that we provide the appropriate level of care as quickly as possible and get them out as quickly as possible.

Chairman STARK. Is that old guy among the quick?

Mr. HUNTER. He is not with us now.

Chairman STARK. Make a buck on a Spring-made sheet. What a great slogan.

Mr. HUNTER. The family is still there.

Chairman STARK. I bet they are. Dr. McDermott.

Mr. McDERMOTT. I was listening to you and I realized there are always things you don't understand, so I want to ask a couple of fundamental questions. The disproportionate share payments; are they made in every State in the same way directly to hospitals, or are they handled in each State in the same way?

Mr. HUNTER. If I may speak very quickly on that issue, the disproportionate share in South Carolina under Medicaid, I understand that the Medicaid disproportionate share is handled differently in States. I know it is in North Carolina versus South Carolina. The disproportionate share under the Medicare program, for example, an urban hospital only has to have a 40 percent disproportionate share population to qualify for that additional add-on in their reimbursement payment, where a rural hospital has to have 45 percent of their disproportionate share mixed to be able to qualify for that additional add-on.

That is national, and the Medicare, and the Medicaid is State-by-State.

Mr. McDERMOTT. The money comes to the State and then they send it to the hospitals or is it in your actual payment directly back from the Federal Government for Medicare? Does that money pass straight to you from the Federal Government?

Mr. HUNTER. That is correct.

Mr. McDERMOTT. Medicaid all goes through the State?

Mr. HUNTER. Through the State back to us.

Mr. McDERMOTT. Do you get the money?

Mr. HUNTER. Yes.

Mr. McDERMOTT. Having been a State legislator, I can't help but wonder if occasionally some of that money doesn't get replaced money that the State might put in.

Mr. HUNTER. This year we will get about \$1 million out of the Medicaid disproportionate share program in South Carolina. That will be our total amount that we will receive.

Mr. DAUNER. In California, as in all States, the Medicare is uniform according to national rules and paid directly to the providers. Under Medicaid we qualify for roughly, in round numbers, \$1 billion in disproportionate share payments. To be responsive to your question, the State budget crunch in California has been such that medical payments have not been increased and therefore the disproportionate share payments have to some degree helped make that shortfall. But the State doesn't put up the money for the Federal matching funds.

For the most part intergovernmental transfers from county governments make up the State match and then once the Federal funds are received, those moneys are paid back to the disproportionate share providers that meet the criteria in California, which are 25 percent or more medical and 20 percent or more uninsured.

Mr. McDERMOTT. If a county hasn't got the money to put up to match then they don't get the Federal money; is it from county-to-county different in California?

Mr. DAUNER. The answer is some counties don't put up much money and a few counties put up most of the funds. However, the disproportionate share formula applies to the 80 disproportionate share hospitals in the State out of 550. So the money is disbursed back, but the counties that put up the money receive what they put in plus more, including the Federal funds even though some of the Federal funds are disbursed to other hospitals, in fact some hospitals in other counties.

Mr. McDERMOTT. So some people are paying for other people. There is actual cost shifting there in a sense?

Mr. DAUNER. There is a modified form of cost shifting in that arrangement yes, sir.

Mr. GAGE. We could spend 2 or 3 hours on this and still not fully understand all the ways in which States are using Medicaid disproportionate share payments. The short answer is that the universe is generally divided into those States which we believe make effective use to provide health care and those that don't. We were in part responsible—I hate to admit this—for the invention of the concept of the disproportionate share adjustment back in 1981 in the Medicaid program and then in 1982 working with this committee on Medicare.

Medicare is consistent nationally even though there are differences within the program between rural and urban hospitals. There are many States that in fact do honor the spirit and the intent of the Medicaid disproportionate share adjustment and do provide payments to hospitals that serve large numbers of low-income patients, and the money does in fact largely stay in the health system.

I say largely because there are States that have had very serious budget crises. California is one State where it is likely that medical payments would not have gone up in any case without disproportionate share. Perhaps there was a bit of a substitution effect in California, but they would have been in very big trouble without the ability to use disproportionate share adjustments to let counties in particular help subsidize the State's share.

There are Federal requirements. You cannot as a county transfer money and expect to get back dollar for dollar what you have transferred, and the Federal Government tries to impose limitations. But there are States that do use the funds for a variety of purposes, and I think that is what we went through in the debate on the budget reconciliation this summer. It is one of the reasons that the concept of disproportionate share adjustment on the Medicaid side of the equation is getting a bit of a bad name in Washington.

I think perhaps the time may be coming in health care reform to retire the name, but to retain the basic concept that there are categories of hospitals that do provide services above and beyond the ability of Medicaid and other health plans to finance them. Those services and costs will remain in the system unless we want to eliminate from our system the very concept of a safety net or provider of last resort, or significantly reduce access in inner cities.

Mr. DAUNER. Dr. McDermott, one more point on the subject as it relates to California and the other six States that have the illegal residents. Two million illegal residents live in California and except for obstetrical and emergency care they are not covered for the most part. Because we have a disproportionate number of those individuals without resources or insurance, they tend to also fall on the safety net providers and without some way of helping ameliorate those losses those institutions couldn't survive.

In Los Angeles County, the county hospital system which operates five hospitals, last year delivered 75,000 babies to mothers who were illegally in Los Angeles County. We have to deal with those. Those people come to the doors of the hospital requiring care, and that is an indication of the magnitude of the problem that exists in certain communities.

Mr. GAGE. I might add that the Medicare disproportionate share adjustment isn't broke. It is consistent and fair. It may well be that there is a distribution problem, as with rural hospitals, and there may be some equitable changes that need to be made there. We will certainly accept that. But unless you make dramatic changes in the Medicare program itself you will continue to need this adjustment.

Mr. McDERMOTT. One of the questions that comes to mind when you raise the issue of the White House's proposal to fund health care reform by cutting Medicare and Medicaid or to reduce the

amount of increase or whatever euphemism you want to use is the question at what point do you think it is reasonable to begin reducing the disproportionate share payments?

How would you design a system that says we don't have to pay disproportionate share payments any more? Would it be 20 percent into the phasein or 50 percent into the phasein of universal coverage or would it be when everybody in the country is covered.

Mr. GAGE. Since under the Clinton plan the proposal is phased in State-by-State, the first thing that needs to be done is to pay attention to the rate of phasein of any States. There are rumors that there is a question of proposing that it be eliminated altogether on the first day that a State comes into the program. Clearly that would be unacceptable, and not just to providers; it would be unacceptable in terms of what it would mean to withdrawing these funds from the health systems. So some sort of phasein is clearly needed. I don't know if it is 20 percent per year.

Clearly if we can reach a point where we can predict with certainty how many uninsured are in fact going to have coverage and know how to use it properly, we could come up with a sliding scale. The other point is that it cannot be eliminated altogether. There will be services and patients outside of this system for many years to come, including not just prisoners and illegal immigrants, but also many patients who are not going to know how to access the system even after they are given a little card. Even today patients with Medicaid cards who are enrolled in managed care plans show up in the same neighborhood clinic or public hospital that has treated them for years and don't understand why there is even a chance they might be turned away.

Mr. DAUNER. Dr. McDermott, on that question, if we go to a coverage system which is universal there will always be some legal residents who fall through the cracks. We have to acknowledge that. Every nation has the same problem regardless of their system. We can eliminate disproportionate share payments once we get to that stage as long as we have a program that then pays those providers when they receive those patients and have to care for them.

We don't have to call it disproportionate payments, but there needs to be a program that individually pays those providers when they treat those people that are outside the system.

Chairman STARK. We can eliminate disproportionate share tomorrow if everybody who came through your door who wasn't in a system—you said in a bill—and this great program—would get the DRG payment. I give you the DRG payment for every uncompensated care patient even up to the percentage of the DRG you would be home free, wouldn't you?

Mr. DAUNER. No. I would have a problem with just getting the DRG payment and the reason is the people that are outside the system are not receiving the preventive services and the other services necessary to be a part of the mainstream. These individuals by definition are going to be—

Chairman STARK. You are only getting 70 percent. If I give you 93 percent you are a lot better off than your—

Mr. DAUNER. Except that those people at their points of entry in the emergency room are normally less healthy and sicker, and

there needs to be a program that recognizes that, and I am not sure that just an average DRG payment that assumes that they are part of the homogeneous population——

Chairman STARK. I am not sure that in those Los Angeles hospitals that you are suggesting is the case. I am not sure that you can make the case that people on Medicaid are getting all that much better primary care in that area of Los Angeles or East Oakland than the street vendor off the books who doesn't pay Social Security or any withholding and therefore would fall through the cracks.

I think you would have to make—I can see that on occasion, if you picked up a homeless person who happened to get off at the wrong stop who wandered into a hospital, but I don't think you can make a case where you have a hospital that had a large disproportionate share of population. I think you are making too fine a cut there. But we have to see.

I am saying that if you got paid whatever the system was able to arrange, then disproportionate share doesn't exist. I don't think that is what the President has in mind in that program. I think there is a discontinuity in your cash flow that is going to—did you have.

Mr. McDERMOTT. I would like to move to another issue because when we put H.R. 1200 together we had a long discussion about what you do with the question of capital. You haven't said a lot about capital.

Chairman STARK. I don't think it is addressed in the President's bill.

Mr. McDERMOTT. No, I don't think it is addressed in the President's bill, and clearly you have to figure some way to deal with capital. What we did in our bill was to make an allocation on historical facts to States for capital money.

Now, we can argue with that and we really didn't know what to do. We certainly didn't think that it would work to put a certificate of need process back in because anybody that has been around a while knows you can game that one to death. It has been gamed everywhere that I know of. So the question is what we did was insert it into the budget, say to the hospital here is your capital money. You can do anything you want with it as long as you have the money to operate it once you have built it or once you have put in this new machine. Don't come back asking for more money to run it. So you have to budget both the construction and the operation of it.

I would like to hear you discuss the most rational way to figure out how to distribute capital money, because I know a charity hospital in New Orleans right now is building another hundred some odd million dollar hospital and I don't know how many other county hospitals are in the process of thinking they will tear one down and build a new one.

How do we get hold of the capital issue? That is sort of a blue-book question you can go anywhere you want with, but it is a real tough one, I think.

Mr. DAUNER. Well, Mr. Chairman, from the point of view of the entire hospital community, I will speak to it from California. Number one, rural hospitals and safety net hospitals have infrastruc-

ture deficiencies today which are abnormal, so we need to deal with that subject we have already talked about, having a program that pays them when people come in that are not in the system.

Generally speaking, if we separate capital from the operations, we are perpetuating a situation that moves in the wrong direction. If we integrate the payment and say you have this much money for this defined population that enrolls in your system and it is an integrated network, we don't need to worry about capital versus operations. They will have an amount of money. They have to deliver the care. They have the ingenuity at the local private level or public level to decide the best way to deploy resources to provide the uniform benefit package.

I don't think we should tell them from top down, you have this much for capital and this much for operations. As a matter of fact, every 3 years, you spend in operations what your original capital investment was, and simply setting aside money for capital I think creates the wrong incentive for efficient delivery of integrated services over the long term.

Mr. GAGE. Capital needs to be broken down into two parts. One of those parts we have been talking about all along, and that is the ability to ensure that payment rates are reasonable enough to enable providers to pay back the cost of capital debt that needs to be incurred to rebuild facilities. But gaining access to the capital markets is also a serious need, and I think that is one thing we haven't been talking about.

I think a rational payment mechanism—I think I agree with Duane—is one that pays a needed facility for providing the services it needs to provide, and permits it to have an adequate physical plant. Payment rates must therefore inherently include capital payments, whether they are identified separately or not.

The problem is getting from here to there for some of the major urban public hospitals. Charity Hospital of New Orleans is clearly one of those, but there are many others, in New York City and Chicago and Los Angeles and elsewhere. We actually have a piece of legislation that Chairman Stark has introduced now for the last 2 years, which we invite you to cosponsor and support. This bill would at relatively little cost to the Federal Government improve the ability of urban and rural safety net hospitals and clinics to gain access to capital in a variety of ways. We have worked on this with the Rural Health Association as well as with the community health centers. The bill includes loan guarantees direct loans and interest subsidies and in rare cases, direct grants.

Some of those provisions we understand, or hope, are going to be included in the President's proposal when it sees the light of day. But we certainly expect that access to capital is very important. In effect a level playingfield doesn't exist right now for these hospitals.

The ability to repay capital is clearly the second important piece, one that really goes to the heart of the way the payment mechanisms under this new system are designed.

I might comment that Charity Hospital in New Orleans, in their struggles with capital over the last several years, is a very good example of what public hospitals are forced to go through in our current system. Charity Hospital, with accreditation problems and a

55- or 60-year-old physical plant, has been forced to downsize continuously from 1,200 beds to the point where I think they have about 550 open today. They have in fact bought an existing non-profit hospital across the freeway, and and so they purchased an existing hospital and now are going to be building a second tower of that hospital rather than a whole new hospital. They are just trying to do this as inexpensively and efficiently as possible and at the same time not bring a lot of new beds on line in that system.

But determining how many beds are needed overall and what kinds of services are needed is the other piece of this. I am not proposing to bring back health planning in those States that have abandoned it, but we do need a mechanism for deciding which facilities need to be rebuilt and supported.

Mr. McDERMOTT. At the national level? At the State level? Where would you put that mechanism, whatever we are going to call it?

Mr. GAGE. I think that depends on the kind of system we develop for allocating access to capital. I believe that can be done at the Federal level. I think there are some States that are also capable of doing it. I think there are other States that aren't.

Mr. McDERMOTT. But certificate of need, you are not calling for again, or do you think certificate of need could work with a—with some adjustments in the way it was written?

Mr. GAGE. I am not going to argue for mandatory certificate of need in the entire system for those States that have done away with it. But I do think that you can have a program of very targeted Federal assistance which can require rural and urban hospitals and clinics to demonstrate the need for those facilities before getting access to Federal support which is what this legislation would do. I don't think you should simply hand it out to everybody who asks for it.

Mr. McDERMOTT. I would say, the experience of running for Governor, as I was going around one of the rural areas, they showed me a large x ray unit in one of the hospitals which was clearly over the limit of certificate of need and I asked them how they did it. They said, very simply, we brought it in two pieces—one piece at a time and then they wired it together and they got around the whole certificate of need process simply by creative electronics. So I have always been a little dubious about whether it was possible to design something that made sense, although sort of conceptually you think it would work, but not when you get down to the operational level.

Mr. Hunter.

Mr. HUNTER. Of course, access to capital in rural areas is of grave concern. If you look at Medicare reimbursement currently and the capital add-on that is built into—blended into the DRG where we used to get a separate capital adjustment, as we continue to shift more patients over into the outpatient setting, which we are doing in my facility—for example, about 60 percent of our total surgical volume is now on an outpatient basis—so as we shift more to outpatient and we have less inpatient and that capital is blended into the DRG, then we overall are losing the capital that we were receiving a couple of years ago. And then even if you look at OBRA 1993 that is calling for capital reductions, and that impact

on my facility this year on OBRA 1993, just on the capital alone is about \$100,000 in less reimbursement.

Mr. McDERMOTT. Yes.

Mr. DAUNER. Dr. McDermott, if we combine the payment for a set amount of services and we don't separate capital out from the operational payment, I believe that we will create at the delivery site the view that everything that they deploy is a cost center, not a generator of revenue, and then there will be a different attitude about what capital needs there are and how the capital should be expended. If we keep the mentality that these are generators of revenue, we tend to go against the grain of economic discipline.

Mr. McDERMOTT. So if you have got capital money, you want to spend it for that, whereas if it is all in one bag and it is allocated but not dedicated to that, then you can make your own decisions.

Mr. DAUNER. Yes, sir.

Mr. McDERMOTT. Let me ask another question, because this is one that—I was talking to the Canadians about their system and they were saying that the next big thing that is going to come out in Canada is Canada's system is failing because they are closing hospitals, and he said the answer to that is of course 40 years ago, 30 years ago, we built a lot of little hospitals all over Canada where there weren't paved roads and snowplows and whatnot, and now it doesn't make sense for us to have these hospitals. And as I look at managed care, I sort of feel like small hospitals around this country, rural hospitals, are going to die by survival of the fittest, and that may not be the most rational way to do it.

I would like to hear you talk a little bit about a rational way to decide if we are going to close hospitals in rural areas, and I realize rural hospitals are in some—in many towns, the major employer, and if they close, then the bank branch goes and you have in these rural areas an awful lot of pressure to keep these hospitals open. But if we are going to close them as a part of this system, what is the mechanism by which we do that that makes the most rational sense, rather than sort of let each town sort of fold on their own as they can't work it.

Mr. HUNTER. One of the first things would be equitable reimbursement for rural hospitals as compared to urban hospitals, and in my facility, for example, and I think that this is true in a lot of rural hospitals that will survive, a rural hospital is no longer just a hospital.

For example, in my facility, of course we are a hospital, we are a long-term care facility, we have a home help agency, we work very closely with the home help department, the department of social services. We are the center of the entire health care delivery system for those 35,000 residents in our county, and we are the access for them into the health care delivery system.

Mr. McDERMOTT. Do you still send people up to—I don't know where your State medical school is. Is it in Columbia?

Mr. HUNTER. It is in Columbia.

Mr. McDERMOTT. Do you care for people up to a certain level and say, We can't handle you here, you have to go to Columbia for that?

Mr. HUNTER. For specialized care we do refer our patients on. Geographically we are located between Charlotte, N.C., and Columbia, S.C. We are closer to Charlotte than we are to Columbia so

Carolina's Medical Center in Charlotte has been our regional referral trauma center for about 15 years now and we send those patients in that direction. We send our major cardiac patients down to Columbia to Providence Hospital. We send our neonates over 40 miles away to Spartanburg Regional Medical Center. So we have them going in separate directions for that specialized care.

But our community does indeed look upon us as the provider of primary care to that community.

Mr. McDERMOTT. So you truly are primary care and have not tried to develop the extensive cancer treatments or the other sorts of things that might—

Mr. HUNTER. Absolutely not, no, and I think that further I would like to add that—you know, those hospitals, rural hospitals that have not kept current with technology and have not kept their plants current and up to date, those are the ones probably that will have just a tremendous disadvantage in the future to be able to survive.

Mr. McDERMOTT. Do you have an ICU and a PCU?

Mr. HUNTER. We do. We have a 6-bed intensive care unit and an 8-bed progressive care unit. We downsized our hospital, or we prefer to use the terminology right-sized our hospital, and we went from 119 acute beds to 82 long term and we increased—I mean 82 acute, and we increased our long term from 62 to 100, increased our outpatient capacity. We feel that strategically, that we have done everything that we needed to do to provide all the services that our community needs.

Mr. McDERMOTT. If you just got paid fairly.

Mr. HUNTER. Right. And to me, and I am sure a lot of people may disagree with this, but I feel very firmly that if there was a single national rate and everyone was paid the same, then let the best man win and those that can't make it on a single rate, and we are all on equal footing and they close, so be it. That is my personal feeling.

Mr. McDERMOTT. Mr. Dauner.

Mr. DAUNER. Mr. McDermott, you hit a key point, that there is not a critical mass of people in rural areas to support the full services, and therefore, how do rural hospitals exist.

It seems to me that we need to pay rural providers on a negotiated rate, or a budget that allows them to function and provide the services locally because it is less expensive for about 75 percent of the care to treat them locally than it is to cart them off to an urban area.

Second, we need to have more flexibility for alternative rural settings so that the facilities in rural communities are not viewed as having to meet the same standard as the hospital of 100 or 200 beds or 1,000 beds in an urban area. They can deliver certain services, primary and secondary services in a high-quality manner, and we need to recognize those differences.

The rural hospitals cover the map. Now, you heard about one here that has 80 beds. In the northeastern corner of California, Surprise Valley Hospital, the only hospital in the county has two acute beds and 14 district partners in facility beds. In the winter, though, that community is 2, 3 or 4 days from the next one, and

the young couple that was snowbound that received all the national publicity this past winter ended up in that hospital.

So we need services there and facilities, but flexibility should be allowed so that they can deliver alternative services less than what we would expect out of a full-service urban hospital.

Mr. GAGE. Let me comment briefly. I don't feel competent to comment on rural hospitals, but I could make a couple of general observations.

First, and I think Duane will bear this out as well, I don't think the universe of hospitals in the health industry today care needs much more assistance from the Federal Government to start downsizing.

In the private sector, the pace of consolidations and mergers that result in the elimination, not just of beds but of entire hospitals, is already well advanced. Even if nothing changed in the health system today, with what is already changing on the Medicare and Medicaid front, and with the way private payers are responding to their own pocketbook constraints, you are going to see a lot of converted hospitals closed or downsized in rural and urban settings.

I think the concern I have is that we not place artificial constraints on those hospitals that we believe are still going to be needed. We have to begin thinking about protecting some hospitals from the competitive pressures that are going to be inevitably brought on them to close. We are seeing pressures from State and locally elected officials who own and operate public hospitals right now that are much more pervasive than pressures we are getting from Washington. Many of these people simply want to get out of the business of owning and operating hospitals. Even though those hospitals are filling a very vital need. You are going to see the rest of the industry falling like dominoes in areas that lose the centerpiece of their system.

If the large public hospitals, such as Kings County or LA County-U.S.C., were to close or be unable to get capital to rebuild, an awful lot of unintended bad things would happen in the rest of the New York City or LA county system.

Now, whether LA County is going to want to support that hospital any longer when you remove a lot of the funding mechanisms that are currently in place and take them to pay for health reform is a different matter. So I think we are going to have to come back around to finding ways to protect certain hospitals because if they do not they are going to close pretty much on their own.

Mr. McDERMOTT. Thank you, Mr. Chairman.

Chairman STARK. Thank you, Mr. McDermott.

I wanted to apologize on behalf of my ranking member, Mr. Thomas. But he had important business this morning and he did ask, and in the great spirit of bipartisanship, I wanted to get two questions that he particularly wanted to address to the panel on the record.

One, I will read his question and then see if he will allow me a little editorial. He wants to know what in each of your opinions is the critical function of these alliances as they are described in the Clinton plan, and is there any other way to achieve the goals of the Clinton plan without regional alliances?

And I must say, I have had this curiosity, too. Are there any of you who think there is anything critical about having a regional alliance and is there anything critical to the success of achieving the President's goals of universal access and cost control by these alliances per se? Saying it another way, could we accomplish health reform without them?

Larry.

Mr. GAGE. It depends on what you call health reform. I think—

Chairman STARK. Universal access, cost control and a reasonable way to pay for it.

Mr. GAGE. If access and insuring the 37 or however many million people are uninsured is what you call health reform, then, yes, I believe there are ways other than these alliances. And I think we have to look very carefully at the notion that we are going to use an entirely brandnew mechanism, we are going to create hundreds of these things around the country for the uninsured.

Chairman STARK. Bipartisanship goes just so far.

Mr. GAGE. Let me add, I do believe that the alliances and the concept of enabling businesses, especially small businesses, to pool their purchasing—

Chairman STARK. That is different. This alliance becomes a—that is a different issue.

Mr. GAGE. I think that that is part of the problem with the way this bill was designed. There were people on this task force and in the White House who believe that is what health reform is and who have paid short shrift to the 37 million.

Chairman STARK. Duane.

Mr. DAUNER. The alliance becomes a single purchaser for everyone that is covered in that area. Now, it doesn't have—

Chairman STARK. All right.

Mr. DAUNER [continuing]. It doesn't have to be, quote, 'an alliance. In most States, my guess is there will be only one and it will be operated by the State.

In California, which has 32 million people, the discussion I am having with the insurance commissioner and the chairman of the two—the two chairmen from the Senate assembly on this joint conference committee is boiling down to a single health alliance or purchasing agent for the entire State, and then having regional offices in certain areas—

Chairman STARK. Do you think that will pass in the State of California? Do you think in the next couple of years, just knowing the makeup of the legislature and the current Governor, that in your personal opinion, would California pass a bill that would create this kind of an entity over arguably the opposition of many groups?

Mr. DAUNER. On its own without Federal legislation, no.

Chairman STARK. Mr. Hunter, do you need alliances in South Carolina?

Mr. HUNTER. I think that what we need to look from the rural perspective and really in the entire issue, logically, it would be more appropriate to evaluate on a small level and then go big instead of starting big and trying to force it into a small level, and the National Rural Health Association would propose developing a model with a smaller network in place, and I will reference back

to the Wisconsin Hospital Cooperative, and to develop a model that will work in a rural area.

Chairman STARK. Thank you.

The other question that Mr. Thomas wanted to ask is in regards to individual plans operating in an alliance. If the plan's premium exceeds the allowable amount, budget cap, the alliance can reduce the premiums of, I gather, all health plans, which one presumes, although it is not required, would reduce payments to providers. The alternative I suppose is you could reduce services to beneficiaries. There is nothing in the plan that would—as long as you don't go down to the minimum or you could tighten up on gate keeping.

How would your hospitals respond? Would you take a cut in margins if you have any or would you see this as I think with the threatened access for quality? How do you respond? I know you deal with us on that every year when we cut your DRG rate of increase.

Mr. GAGE. Well, the so-called backstop budget controls are still, from having read it more than twice, something of a mystery as to how they would function. It appears to me that they start with this National Health Board and they come down to the States and the States impose targets and reductions on the alliances and the plans and the providers. So it may not even be in the discretion of the alliances to impose these retroactive reductions to make up for the amount by which plans or providers exceeded the target last year. I think it is safe to say we would have serious concerns with that.

We are looking for predictability, not unpredictability, which is what we have now in the system. That appears to us to go in the opposite direction.

Chairman STARK. Duane.

Mr. DAUNER. My understanding, Mr. Chairman, is that the alliance would be given a total budget and that budget is determined for a given year by taking the average weighted capitation payment, multiplying it by the number of people in that alliance region, and then if the alliance, in negotiating with plans, ultimately doesn't meet that budget—

Chairman STARK. Let's say no plan will come in for that premium. For example, if you have three or four plans in an area and they all say, Hey, we aren't going to take that risk so we are—I mean, there are a variety—or one plan is over. There are a variety of scenarios, but assuming that they are over budget, they reduce the premium.

Mr. DAUNER. My understanding from reading the section, I think it begins on page 93 of the plan, says that the alliance would do one of two things. It would either assess the plans and the providers in the plans that caused it to go above its budget, or would reduce from their next year's payment an amount to recover what they ended up spending that caused the alliance to go above its budget.

Chairman STARK. And the plan in turn could reduce payments to you?

Mr. DAUNER. That is correct.

Now, there are two aspects to that. One, I think this is a built-in incentive, maybe regressive, but nevertheless, it would move the

plans to become integrated and would tend to eliminate the fee-for-service indemnity-type arrangements because they would be the highest cost options.

And then second, speaking specifically for providers, if we are a hospital in one of those plans and we receive an assessment toward the end of the year for \$500,000 or \$300,000, most of the California hospitals couldn't pay it. There are a handful that could, but the vast majority could not.

Chairman STARK. Let me get to one other thing. The doctors are not the only fee-for-service providers in this continuum, are they? Your hospitals, in a sense, provide fee-for-service service?

Mr. DAUNER. Correct.

Chairman STARK. Either in conjunction with a physician or in some cases directly to individuals so that you are in that box as well, aren't you.

Mr. DAUNER. Yes.

[The prepared statement follows:]



TESTIMONY
 before the
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
October 22, 1993
 for the
CALIFORNIA ASSOCIATION OF HOSPITALS
AND HEALTH SYSTEMS
 by
C. Duane Dauner, President

Good morning, Mr. Chairman and members of the subcommittee, I am C. Duane Dauner, President and Chief Executive Officer of the California Association of Hospitals and Health Systems (CAHHS). Today I am testifying on behalf of the nearly 500 member hospitals of CAHHS on President Clinton's health reform proposal.

On the issue of illegal residents, I am testifying on behalf of the hospitals and hospital associations in California, Arizona, New Mexico, Texas, Florida, Illinois, and New York.

We endorse the testimony presented to the subcommittee by the American Hospital Association (AHA). The vision of California hospitals is consistent with the vision of AHA. Our statement is offered in support of the AHA position.

The California Association of Hospitals and Health Systems supports President Clinton's goal of achieving universal coverage and access to an affordable, standard benefit package. We applaud the President's leadership to resolve the crisis and achieve the California hospitals' vision that every resident have equitable access to affordable, quality health care, including physical, mental, and substance abuse services. Further, CAHHS supports the plan's overall concept for achieving universal access through a restructured delivery system, as well as many of its underlying elements. It would implement several needed reforms in the health insurance market. However, there are several issues which create concern, and if implemented, will not release the market forces necessary to create comprehensive restructuring of the health care system.

The following represents the position of California hospitals on key elements of the President's proposal for health reform.

MANAGED COMPETITION

CAHHS supports the concept of managed competition if it is based upon compatible incentives which interact to encourage changes that achieve universal access, quality, and economic discipline. California hospitals have long shared the philosophy of President Clinton's health reform proposal. Realigning incentives for all persons in the health care equation is the solution for providing cost effective and medically efficacious care. Full integration aligns the incentives for patients, providers, health plans, employers, and the government, and motivates all to work together.

FINANCING

CAHHS is alarmed with the President's proposal to reduce Medicare and Medicaid spending by \$238 billion to finance health reform. This cut is in addition to the \$63 billion in Medicare and Medicaid reductions that were adopted as part of OBRA 1993 and the \$43 billion in cuts from OBRA 1990. California hospitals believe that the proposed reductions will jeopardize access and quality for all Americans, especially the elderly and poor.

The proposal also would be a vehicle to reduce the federal deficit. We believe that any savings which accrue from the reform of the health care system should be redirected into the system in the form of financing for illegal residents, strengthening of safety net and disproportionate share providers, and increasing subsidies for small, low-profit businesses and low-income people.

CAHHS questions the wisdom of leaving Medicare out of the system. California hospitals will be operating under two different reimbursement principles and incentive systems: capitation for nearly 65 percent of their business, and modified fee-for-service DRG Medicare payments from 35 percent of their patients. The resulting inconsistent set of incentives and reimbursement methodologies will not be conducive to achieving the goal of an efficiently operating health care system. Further, it places many of the components of the health care equation at odds with one another. We recommend that incentives be established which will encourage Medicare beneficiaries to enroll in lower cost delivery options.

HEALTH ALLIANCES

CAHHS believes that health alliances can play a positive role within the managed competition framework. However, California hospitals have the following concerns with health alliances as defined in the plan:

- The President's proposal to require all employers with less than 5,000 employees to be included in an alliance weakens the pluralistic nature of health care financing. The proposal will essentially create a single payer system, or at least a single purchaser system with all-payer implications. Alliances would dictate to the local level the rates and price controls which are established by the National Health Board. To assure the vitality of a pluralistic financing system which is responsive to local needs and priorities, California hospitals believe that the health alliances should be limited to covering employers with 100 or fewer employees.
- The plan assumes that health alliances will be operational in a short time, which places considerable dependence on organizations which do not exist. If alliances fail because of unrealistic expectations, increased top-down regulation of the health care system will be a likely result. We believe that the best long term interests of the public will be served if incentives, rather than regulatory controls, are the motivation for patients, providers, and payers to change.

HEALTH PLANS

Health plans should be integrated with providers, sharing common goals and incentives. They should be responsible for the delivery of health care to an enrolled population. Individuals should be able to choose among competing health plans annually. These plans, operating within a capitated payment framework, will be responsive to the right competitive pressures: quality, service, price stability, local responsibility, and the motivation to improve health status rather than provide more and more services to generate revenue.

CAHHS questions the definition and qualifications of health plans. California hospitals believe that the federal government should establish an overall framework that is consistent from state to state, but should leave room for local flexibility. California hospitals support flexibility so that plans can be responsive to local needs. The definition and capitalization requirements should be sufficient to prevent the creation of store front brokerage plans that become simply a conduit to receive capitation premiums, then hammer providers with reduced payments, having little concern for quality and access.

COST CONTAINMENT/QUALITY OF CARE

Rather than relying on cost controls and top-down global budgets, the health reform strategy should rely on congruent incentives to keep costs down and produce economic predictability. Efficiency and cost containment will occur through price, service, and quality competition among integrated community health networks.

The Administration's proposal for creating a global budget calls for stringent and rapid cutbacks in the rate of increase in health care expenditures. Further, alliances would assess individual

health plans and providers retroactively if their nationally-assigned budgets are not achieved. California hospitals believe this formalistic, front-end/back-end approach to such a complex issue fails to recognize changes in technology, socio-demographic changes, and new diseases. As all price controls imposed in the last 25 years have shown, incentives for innovative programs and improved care will be sidetracked and replaced by strategies to survive and outsmart the regulators. Rate setting in health care will create underfunding, promote unbundling of services and expanded utilization, and will subject the well being of patients to the political budget process.

ILLEGAL RESIDENTS

The uncompensated care that hospitals provide to illegal residents has been dramatically increasing. The problem of uncompensated care affects hospitals in every state; however, the losses due to care rendered to illegal residents makes more acute the uncompensated care burden in several states. According to unofficial estimates from the Bureau of the Census, there are more than four million residents in the United States illegally, and over fifty percent of them live in California.

The Administration is considering the establishment of a five year transitional Vulnerable Population Adjustment Pool to deal with the health needs of illegal residents. The states most affected appreciate the recognition of this problem, and recommend that a long term program be established to provide payments to providers that treat persons who do not have a health security card or receive coverage through the national program.

The annual cost of care given to illegal residents in California exceeds \$1.5 billion, more than half of which is not reimbursed. Illegal residents, as well as legal residents who fall through the cracks of coverage, will continue to use health care services, usually through hospital emergency departments and safety net providers. Funding for the pool must be adequate to cover the care which will be rendered outside of the universal program.

ANTITRUST REFORM

CAHHS supports the Administration's recently released antitrust guidelines for hospitals. California hospitals, however, believe additional latitude is needed to permit providers to enhance the efficiency of the system, conserve resources, and better serve patients. Some of the guidelines are overly restrictive and will preclude several cost-saving activities and arrangements among hospitals and physicians.

MALPRACTICE REFORM

CAHHS supports malpractice reforms. California hospitals believe that the national reforms should be based upon California's Medical Injury and Compensation Reform Act of 1975 (MICRA). The California laws contain important restraints on non-economic damages and contingency fees, and include other key provisions which substantially reduce malpractice costs. The courts have upheld MICRA, thereby creating a reliable body of law.

Mr. Chairman and members of the subcommittee, I wish to reiterate the commitment of California hospitals to the principles of health reform as outlined by the President. The principles are consistent with the "Vision, Values and Conditions for Health Care Reform" of California hospitals, a copy of which is attached. We look forward to working with you in developing a proposal that is consistent with pluralistic market principles which are based upon congruent, system-wide incentives.

Thank you.

CALIFORNIA HOSPITALS' VISION, VALUES AND CONDITIONS FOR HEALTH CARE REFORM

(Approved January 21, 1993;

Amended April 20, 1993)

Health Care Reform Vision

California hospitals share a common vision:

"California hospitals believe that every person living in California is entitled to equitable access to medically necessary quality health care including physical health, mental health and substance abuse services. Hospitals envision an optimally healthy society which is supported by a viable health care infrastructure that reflects economic discipline and predictability. The health care delivery system should be dedicated to improving health status, promoting preventive practices and wellness, and delivering coordinated and appropriate health care services."

Hospitals in 1989 established as the foundation for health care reform the principle, "Society, acting primarily through government, has an obligation to assure equitable access to necessary health care as a basic human right and an essential condition of productive participation in society." Our obligation extends to all Californians, including the most vulnerable populations.

The vision can best be achieved through meaningful dialogue and a private-public partnership which is motivated by interactive, balanced incentives that affect all interests/stakeholders. Systemic changes are necessary and enlightened legislation is the preferable way to create the framework for constructive reforms.

A strong nation depends upon healthy people. Hospital and other health care leaders have an opportunity and responsibility to their patients and their communities to help make this nation the healthiest in the world. California hospitals are committed to this goal.

Values

Underlying values are essential for long lasting reforms which serve the public interest. Among the most important are the following:

1. **Health care is a service which must be available to everyone.** Caring for people transcends the values of such things as products and commodities. Health care is a personal service which should not be restricted because of the racial, ethnic, religious or financial position of any individual.
2. **Health care exemplifies the ultimate human element.** Each person receiving health care should be treated with respect and dignity, realizing the value of life. Dignity extends beyond individuals or groups; it is realized only in association with all others in society.
3. **Health care is an individual and societal responsibility.** Each person bears certain responsibilities for his or her own behavior and life. In the aggregate, similar responsibilities rest with society. Limited resources must be managed wisely and public health policy must reflect society's values. The role of government must be supportive of individualism, recognizing diversity and choice.

Conditions

Before structural changes can occur, agreement must be reached on fundamental requirements. Hospitals believe that the following statements lay the foundation for building a modern health care system that breathes life into the vision and optimizes the health of every person.

1. **Health Status.** The fundamental goal of the health care system must be to achieve the best possible health status of the population at a cost society is willing and able to afford.

2. **Basic health services for everyone.** All individuals must have timely equitable access to legislatively defined physical and mental health care services, augmented by a network of support which is designed to improve health status. To be effective, the health support and health care services system should serve the public good, provide equitable access, and utilize resources wisely.
 3. **Quality.** The concept of quality must have three dimensions - quality of life, quality of health support to improve health status, and quality of health care services. Recognizing that the value of life and treating all people with dignity are essential ingredients of quality, the outputs of health care services should be measured against established guidelines and used to improve quality. Measurement and reporting of outcomes are needed to ensure that all interested parties have sufficient information to make responsible decisions.
 4. **Affordability.** Health decisions are too important to centralize in any single body; everyone must have a stake in determining what is appropriate and affordable. Affordability means a community focused structure which provides timely, medically necessary but not wasteful services in the most appropriate setting. Health care must be developed at a cost which individuals, organizations, and society can afford without risking serious medical or financial consequences. The cost of health care must fit within the overall economic well-being of the nation.
 5. **Efficient delivery of services.** The management of health care costs is a shared responsibility which must be met to achieve equitable, universal access. Delivery and financing mechanisms should align the incentives of the patient, the payor and the provider to promote continuous improvement in the efficient use of resources, produce economic discipline and predictability, and, wherever feasible, eliminate conflicts of interest, redundant administration, duplication, and the furnishing of inappropriate services. Financial and other incentives, properly constructed, will produce constructive behavioral changes and provide the foundation for long term success. Community adjusted capitation payments to vertically integrated systems or community care networks (e.g., prepaid health plans, health maintenance organizations [HMOs] and other comprehensive delivery organizations) hold the greatest promise for achieving universal access and economic discipline. Problems such as excess capacity, duplicative allocation of resources and inefficient or unnecessary utilization should be managed within an integrated system to generate efficiencies and improve quality. Through systems or networks, continuity of care is established and providers' services are coordinated to ensure fast, efficient services to patients. The efficient delivery of health care services becomes a consequence of managed competition.
 6. **Adequate and fair financing and payment systems.** Adequate funds must be available and the payment arrangements must complement the systemic model. Pluralistic financing sources, private and public, provide a blend of social policy forces which add responsiveness and responsibility to the health care equation. Employers should provide coverage for employees and their dependents, with government providing coverage for the elderly and unemployed uninsured. Individuals should have the freedom to choose among competing systems or networks; however, each person should share in the financial responsibility of health care through participation in premiums and co-payments. The payment system should support improving health status, preventive practices and wellness. Managed competition, without price controls, caps or arbitrary budgets, holds the greatest promise for achieving this goal.
- Federal and state tax policies affecting employers, employees, individuals and government must be congruent with the overall health policy as well as specific goals. Further, tax policies such as taxes on tobacco and other products which are harmful, should be consistent with the health care vision.
7. **Appropriate supply of health care professionals.** Policies and funding for the education and training of physicians and other health care personnel, with research and continuing education, must be compatible with the goals of access and quality. Additionally, incentives in the payment system will encourage a more equitable distribution of health care professionals.

8. **Special populations and circumstances.** Unique situations exist which require specific accommodations, including rural communities, urban areas where people fall through the universal care fabric, traditionally excluded populations, specialty services and stand-by services which must be continuously available or are used sparingly. Reforms must accommodate these situations, regionally where appropriate, and locally. Systemic changes should include integration or coordination with public health services.
9. **Removal of barriers.** The development of competing vertically integrated networks is impeded by barriers in the areas of antitrust and tort law, insurance practices, tax policies, impediments to necessary relationships and arrangements between hospitals and physicians, government's failure to pay its fair share of the costs and shifting of its costs to the private sector, and inconsistent governmental policies. Corrective action is essential in the reform process and is as critical to a long term solution as affordability and quality.
10. **Participant-friendly.** Persons of all cultures and socio-economic backgrounds should have a dependable entry point and receive coordinated health promotion support and medically necessary services. Similarly, providers should be able to fit into networks without burdensome governmental red tape or micro-management intervention. The system should be simple in overall design so that individuals are not subjected to multiple sources for information or professional management of their case.
11. **Transition.** Systemic reform of the magnitude anticipated dictates that the changes must be phased in over a period of time. Steps should be taken to prevent untoward distortions or financial breakdowns during the transition.

Summary

The hospitals' vision is attainable, but only if the reforms adopted reconcile the dichotomies of universal access, expectations, increasing utilization and rising costs. Rather than defer to the government, California hospitals prefer the development of a meaningful private-public partnership.

Incentives are needed which encourage responsible behavior from all parties. Balanced roles and responsibilities provide the best foundation for a long term solution. By the year 2000, reforms can be implemented and the United States again can lead the world in health and health care.

Approved by the California Association of Hospitals and Health Systems Board of Trustees - January 21, 1993.

Amended by the California Association of Hospitals and Health Systems Board of Trustees - April 20, 1993.

Chairman STARK. OK. Now, Mr. Hunter, did you want to add to that?

Mr. HUNTER. The only thing I would add to that, of course, like I mentioned earlier, we don't have any experience with alliances in my area, but from a rural perspective, I do think that it would jeopardize quality and restrict access.

Chairman STARK. OK, I would just leave you with one thought. I will spoil your day. Read, I think around in 192 in that missive, there is something called Medicare managed care. They dispense with it in a couple of paragraphs, and it talks about experiments and requiring every plan that qualifies to offer a Medicare managed care. And then it further offers that people in fee-for-services can bid, can go to certain providers at a point of service and for specific procedures. We were told in earlier testimony that they might waive the copay if you went to that specific provider for, let's say, cataract surgery. This means in certain communities, they will be bidding among you to see who gets to provide those services, which means arguably others of you would be out of the business, and it is only barely a page. Read it. Read it twice, and I will talk about it later.

Thank you. Thank you all very much. You have been helpful. Appreciate your testimony. I know we will be working very closely together over probably the next year and I look forward to it.

We will recess for 5 minutes.

[Recess.]

Chairman STARK. Gentlemen, thank you for your patience. We will resume. Now that it is just me for awhile, I am going to run the light only to shut me up more quickly and that will mean less pain.

I understand that Dr. Griner has an important appointment and will have to leave not later than 12:30 p.m. And, doctor, if we for any reason run over, you just get up and leave when it is important for you. I appreciate your taking this time. I would like to welcome you as president of the American College of Physicians, and my old classmate, my former classmate—obviously not old—Gerald Austen, the past president of the American College of Surgeons; William Coleman, the president of the American Academy of Family Physicians; and Howard Pearson, the president of the American Academy of Pediatrics.

We welcome you to the committee, and I just ask you to go ahead and present your testimony in any manner you are comfortable, I guess in the order I called on you, and then we will have a general discussion at the conclusion of that.

Dr. Griner.

STATEMENT OF PAUL F. GRINER, M.D., PRESIDENT, AMERICAN COLLEGE OF PHYSICIANS

Dr. GRINER. Thank you, Mr. Chairman, and good morning.

The American College of Physicians is committed to fundamental reform of our Nation's health system and supports President Clinton's blueprint for change. If all of us are committed to reform and keep that central goal in sight, we believe it will be possible to find agreement on the specific elements of the package.

The college supports the President's plan overall because it promises to guarantee health security which will protect the doctor/patient relationship, restore professionalism to medical practice, support primary care and provide meaningful cost containment.

By providing Americans with health security, the President's plan gives peace of mind to millions of American families who will know they can always get the care they need. This guarantee will protect, and actually improve, we think, the doctor/patient relationship.

Right now, many of our patients have limited choice over which doctor they can see. Under the Clinton plan, consumers will be allowed to choose their own health coverage, including a fee-for-service plan or any other plan their physicians belong to. When they change jobs or lose their job, their health coverage will follow them. These provisions will enable patients to forge and continue long-standing relationships with their doctors.

The ACP also believes that serious cost containment is essential to real health reform. This country cannot afford and will not achieve universal health coverage without controlling costs. The college, therefore, supports the Clinton plan's use of a combination of competitive mechanisms and a national health care budget to accomplish this goal.

In addition, the President's plan promises to restore professionalism to the practice of medicine. Physicians today are being overwhelmed by paperwork, red tape, and excessive government regulation.

While our health system must contain methods of quality assurance and accountability, we believe physicians should be given more responsibility and autonomy to make clinical decisions. We want to spend our time taking care of patients, not taking care of paperwork.

The College has long argued that health care reform must restore primary care physicians to a central role in the health delivery system, so we are pleased that President Clinton has recognized the key role played by primary care physicians through increased reimbursement and delivery system changes.

ACP is supportive of the goals and many of the elements of the President's plan, but like all pieces of complex legislation, the plan contains provisions that we feel need improvement. Of primary concern is that the malpractice reform components of the plan are weak. Our Nation's malpractice system does not work for injured persons or for physicians. Lawsuits are time consuming and expensive. Many victims of malpractice do not receive timely and adequate awards. Physicians feel threatened and often believe they must perform procedures merely to protect themselves from liability.

The Clinton plan's malpractice reform provisions do not go far enough. We urge that noneconomic damage rewards to plaintiffs be capped. And in addition, we would add provisions eliminating joint and several liability and strengthening alternate dispute resolution mechanisms.

We are disappointed that the Clinton plan does not guarantee physician representation on the proposed National Health Board. We believe stronger provisions are needed to achieve the adminis-

tration's stated goal of developing provider-controlled, community-based health plans. Physicians must have the necessary tools to compete with traditional insurers and other entities seeking to become health plans.

Finally, while we support changes in graduate medical education to achieve an appropriate balance between generalists and specialists, we would like to work with you to develop the appropriate roles for the Federal Government, academic health centers and private accrediting agencies to accomplish this goal.

Finally, I would like to issue a word of caution about the plan's provisions regarding the role of States. While State flexibility is important, we must remember that the goal of this plan is to reform our Nation's health system for patients as well as for physicians. The Federal Government must set clear criteria and carefully monitor State actions to make sure that goal is achieved.

In conclusion, Mr. Chairman, we applaud the President's initiative, a new system that provides health security to all Americans, provides predictability of health care expenditures, and allows physicians to once again practice medicine free from red tape and interference. We look forward to working with you and your colleagues as the legislation is developed to ensure that these goals can be realized.

Thank you, Mr. Chairman.

[The prepared statement follows:]

Statement
of the
American College of Physicians
Before the
House Ways and Means Committee
Subcommittee on Health
October 22, 1993

The Clinton Health Reform Plan

Good morning. Mr. Chairman, Members of Congress, and distinguished guests, my name is Dr. Paul F. Griner. I am President of the American College of Physicians, the nation's largest medical specialty society, representing 80,000 physicians practicing internal medicine and its subspecialties.

The College is committed to fundamental reform of our nation's health system, and supports President Clinton's blueprint for change. The President has developed a comprehensive proposal, and we pledge to work with him and the Congress to get legislation passed as soon as possible. If all of us are committed to reform -- and keep that central goal in sight -- it will be possible to find agreements on the specific elements of the package.

Mr. Chairman, when physicians look at our nation's health system, they see a system in critical condition. They see that many of their patients do not have insurance. Those that are covered are not secure, because they know that at almost any moment, they can lose their insurance. They see a dissolution of the doctor-patient relationship due to the system's fragmentation and insurance rules. They see more paperwork and bureaucracy, and less ability to make the clinical decisions for patients they are trained to make. In sum, they see a system that doesn't work.

The College believes the President has put forward a workable plan that can fix the health care system for physicians and their patients. Specifically, it promises to:

- guarantee health security which will protect the doctor-patient relationship;
- provide meaningful cost containment;
- strengthen primary care; and
- restore professionalism to medical practice.

Universal coverage and health security protect the doctor-patient relationship

The President's plan guarantees health care coverage for all Americans. It makes clear that health care is a fundamental right -- not an economic privilege.

The ACP has long endorsed universal coverage as an essential piece of any health reform plan. Mr. Chairman, you know the facts. Those without insurance total in the tens of millions. Moreover, those lucky enough to have insurance are at risk of losing their coverage if they change jobs, become unemployed, or get sick.

The consequences are enormous. Because they lack insurance, many of these Americans fail to get the care they need, or obtain it later than they should, in expensive settings. Uncompensated care means that those with insurance end up paying for those without it. In addition, millions of Americans are trapped in their jobs because if they change jobs they lose their insurance.

By providing Americans with health security, the President's plan gives piece of mind to millions of American families who will know they can always get the care they need. Moreover, this guarantee will protect, and even improve, the doctor-patient relationship.

Right now, many of our patients have limited choice over which doctor they can see. Often, their employer chooses their health plan, and that particular plan may restrict their

choice of doctor. If the employer changes coverage, patients often have to see a new doctor. Furthermore, when they change jobs or lose their job, the patient's insurance coverage changes -- again, jeopardizing the continuity of care.

Under the Clinton plan, though, this problem should be relieved. Consumers, not their employers, will be allowed to choose their own health coverage, including the health plan their physician belongs to. Through the mechanism of the health alliance, when they change jobs or lose their job, their health coverage will follow them. In addition, the Clinton plan requires that consumers have the option of either joining a fee-for-service plan or being able to go outside a managed care plan. These provisions will enable patients to forge and continue long-standing relationships with their doctors. This is essential to the well-being of patients and the professional satisfaction of physicians.

Meaningful cost containment

The ACP believes that serious cost containment is essential to real health reform. This country cannot afford, and will not achieve, universal health coverage without controlling costs. Mr. Chairman, we must limit the growth rate of health care spending.

We support the Clinton plan because it is the only plan that directly tackles the rising cost of health care. It does this through a combination of competitive mechanisms and a national health care budget. First, the plan changes incentives in the system, forcing health plans to compete on the basis of price and quality, careful use of resources, administration simplification, and other devices. Second, the national health care budget will act as a backstop. The budget does not call for either price controls or caps on physician fees. Rather, it challenges health plans to work cooperatively with providers and patients to hold down spending.

Limiting health spending will not mean the end of fee-for-service medicine, as some have charged. Indeed, the Clinton plan requires that fee-for-service plans be available to all Americans. In addition, other countries have shown that through negotiated fees, fee for service arrangements can operate within a budget. A fee-for-service plan in which providers practice conservatively should be able to deliver high quality care and compete successfully within premium constraints.

Strengthen primary care

The College has long argued that health care reform must restore primary care physicians to a central role in the health delivery system. In many communities across the country, primary care physicians are working hand-in-hand with other health professionals to provide Americans with high quality and cost effective health services. Nonetheless, far too many Americans still do not get the primary care services they need. Therefore, it is essential that the new health system expand these collaborative efforts. At the same time, it is critical that we increase the supply of primary care physicians by reforming our nation's medical education system and improve the environment of medical practice for physicians who provide primary health services.

We applaud President Clinton for his recognition of the key role played by primary care physicians through increased reimbursement and delivery system changes. We are also pleased that the President is committed to a national policy to eventually achieve a more appropriate balance in the physician workforce. We would like to work with you to develop the appropriate roles for the federal government, academic health centers, and private accrediting agencies to accomplish this goal.

The plan restores professionalism to medical practice

The President's health proposal also promises to restore professionalism to the practice of medicine. Physicians today are increasingly frustrated by the health care system. They are being overwhelmed by paperwork, red tape, and excessive government regulation. While many of these regulations are well-intentioned, and our health system must contain

methods of quality assurance and accountability, physicians must be given more responsibility and autonomy to make clinical decisions.

Insurance practices are also burdensome for physicians. With some 1500 insurance companies nationwide, each with their own claims forms, coverage determinations, and utilization review requirements, physicians often feel as if they are in the insurance business.

Mr. Chairman, it is time to permit physicians to spend our time doing what we are trained to do -- what we want to do. Physicians want to spend their time taking care of patients, not taking care of paperwork.

The President's plan recognizes this. We applaud the initiative to reduce the mountain of paperwork to one insurance claim form, and the creation of a "health security card". We are also pleased that he has proposed regulatory relief. Freeing physicians from unnecessary and burdensome regulations will allow physicians to spend more time caring for their patients, and less time worrying about bureaucrats. For example, in areas such as clinical laboratory requirements (CLIA), it is critical that we strike the appropriate balance between accountability and quality of care, and costly and burdensome intrusions into a physician's practice.

Mr. Chairman, the ACP is supportive of the goals, and many of the elements of the President's plan. But, like all pieces of complex legislation, the Clinton plan contains provisions that we feel need improvement.

Malpractice Reform

A primary concern is that the malpractice reform components of the plan are weak. Mr. Chairman, our medical liability system needs fundamental reform. Instead of our current adversarial system, we should strive to develop a system that focuses on ways to improve the quality of medical care.

Unfortunately, all too often discussions about malpractice reform have turned into shouting matches between doctors and lawyers. That obfuscates the real issue. Our nation's malpractice system does not work -- for injured persons or physicians. Lawsuits are time-consuming and expensive for both sides. Many victims of malpractice don't receive timely and adequate awards. In fact, only six out of every 100 patients who experience adverse outcomes as a result of negligent care receive compensation.

In addition, physicians feel threatened and often believe they must perform procedures merely to protect themselves from liability. A recent poll showed that 78% of America's physicians reported that the threat of medical liability suits causes them to order tests they might otherwise consider unnecessary. This risks patient harm, causes the physician-patient relationship to suffer, and in some instances, patients lose access to certain types of health care.

The Clinton plan's malpractice reform provisions do not go far enough. We urge that non-economic damage awards to plaintiffs be capped. We believe a cap will act similarly to the global budget -- putting boundaries on the system. In addition, we would add provisions eliminating joint and several liability and strengthening alternate dispute resolution mechanisms. We look forward to working with you and other committees to strengthen these provisions.

Physician Role

Another concern is the physician's role in the new system. Physicians are on the front lines of health care delivery, and are responsible for their patient's health. Consequently, they must be an integral part of the management of the new system.

Toward that end, we were disappointed that the Clinton plan does not guarantee physician representation on the new National Health Board, that will be such a vital part of our

nation's health planning and decision-making. In addition, although each health alliance will have an advisory provider panel, we are concerned that decisions about clinical practice will be made without sufficient physician input.

It is also critical that physicians perform quality assurance activities in the new system. Currently, our system of utilization review and quality assurance is overly burdensome. Utilization review is performed on a case-by-case basis by many different entities that use different, secret, and often inconsistent criteria. Moreover, these criteria often do not focus on quality of care.

As we reform our health system, it is essential that we develop a quality assurance mechanism that uses explicit public criteria and balances internal mechanisms of quality improvement with external accountability. While profiles of practice patterns can be used to identify possible problems, physicians and other providers should perform detailed monitoring of quality and problem solving.

Moreover, we believe that as outlined, the plan will not achieve the Administration's stated goal of the development of provider-controlled, community-based health plans throughout the country. Physicians must have the necessary tools to compete with traditional insurers and other entities seeking to become health plans.

For example, the proposal should not require that all health plans be "insurance companies" as defined by many state statutes. Moreover, a physician-governed plan should not be subject to the same capital and solvency requirements of a traditional insurer. In addition, technical assistance, including the opportunity to receive timely advisory legal opinions, should be made available to doctors seeking to form health plans.

No New Bureaucracies

An additional concern that we want to highlight today is the issue of creating unintended bureaucracy. We must remember that health alliances are "purchasing cooperatives" -- administrative mechanisms for pooling people together to help them purchase insurance. While the alliances also serve other administrative and consumer-education functions, they should not become additional layers of regulation and bureaucracy.

State Flexibility

Finally, Mr. Chairman, I'd like to issue a word of caution about the plan's provisions regarding the role of states. As you know, this proposal gives states a large amount of flexibility to design the health delivery and financing system within their borders. In addition, it encourages states that are already developing their own health reform plans to continue that effort.

While state flexibility is important, we must remember that the goal of this proposal is to reform our nation's health system for patients as well as for physicians. Toward that end, the federal government should set clear criteria and carefully monitor state actions to make sure that goal is achieved.

Conclusion

Mr. Chairman, we applaud the President's initiative. The time for reform is now. The status quo won't do for physicians or their patients. A new system that provides health security to all Americans, while allowing physicians to once again practice medicine free from red tape and interference is long overdue. We look forward to working with you and your colleagues as the legislation is developed. Thank you.

Chairman STARK. Thank you.
Mr. Austen.

STATEMENT OF W. GERALD AUSTEN, M.D., IMMEDIATE PAST PRESIDENT, AMERICAN COLLEGE OF SURGEONS, CHAIRMAN OF HEALTH POLICY AND REIMBURSEMENT COMMITTEE

Dr. AUSTEN. Chairman Stark, I am W. Gerald Austen, immediate past president of the American College of Surgeons and chairman of its health policy and reimbursement committee.

The college certainly commends the President for his leadership in proposing steps to bring about reforms to the Nation's health care system. We support his call for achieving universal access to health care and for making needed reforms in the insurance marketplace. However, there are several aspects of the President's plan that are of significant concern to us.

For example, it appears that the plan would restructure the health care system by creating a new and highly bureaucratic scheme. All sorts of new boards, corporations, advisory councils and other quasigovernmental alliances would be created throughout the country to carry out activities such as setting and enforcing global budgets, regulating the content of health plans, negotiating fees, managing the training of physicians, collecting and disseminating vast amounts of data, reviewing quality of care, and so on.

We believe that the bureaucratic scheme set forth in the health reform plan should be examined carefully and with concern.

The college realizes that health system reform will require new financial resources to be invested. However, we believe the administration has unrealistic expectations about financing this effort through very deep reductions in the Medicare and Medicaid programs, largely through significantly decreased payments to those who now provide those health care services.

We are also concerned that the proposed premium caps could quickly lead many health care plans to resort to health care rationing or risk failing altogether.

The fellows of the college are also very much disturbed by an apparent attempt in the President's plan to address certain primary care objectives at the expense of other services. For example, it can be hardly considered fair for the administration to propose paying surgical services less than justified under Medicare's resource-based payment methodology in order to pay more for primary care services than is justified under that same approach.

Similarly, we think it is inequitable and even rather odd for the President to recommend eliminating the 10 percent Medicare payment incentive for surgical and most other physician services in urban health professional shortage areas in order to double the bonus for primary care services that are provided in rural and urban shortage areas.

We applaud features in the President's plan that would provide Americans with a choice of at least three different types of health plans, including plans that allow participants the option of consulting any health care provider subject to reasonable requirements. The college believes, however, that more must be known about the design of the health plan options under the President's proposal be-

fore decision makers can determine if Americans will, in fact, be presented with a reasonable choice of affordable health benefit arrangements, including plans that do not require patients to seek care through gatekeeper mechanisms.

For example, in the case of the so-called high-cost sharing option which the administration presumes will include plans that do not employ gatekeepers, alliances or States would be expected to negotiate fee schedules and other payment methods for services provided. However, if those fees and payments are unreasonably low, true freedom of choice in selecting a plan may not exist in some areas or perhaps exist on paper only.

The college also has major concerns about the President's proposed global budgeting scheme. In our view, that proposal concentrates far too much regulatory authority in the hands of government and alliance officials. We understand the importance of including provisions in the plan that aim to protect universal health benefits in cost-effective ways. However, the college believes that various incentives should be used instead of regulation to contain costs.

Again, I thank you very much for the opportunity of presenting our views. I would be happy to answer any questions that you may have.

[The prepared statement follows:]

STATEMENT
of the
AMERICAN COLLEGE OF SURGEONS

to the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

presented by

W. Gerald Austen, MD, FACS

RE: Health Care Reform

October 22, 1993

Chairman Stark and members of the subcommittee, I am W. Gerald Austen, MD, FACS, Immediate Past President of the American College of Surgeons and Chairman of its Health Policy and Reimbursement Committee. On behalf of the more than 60,000 Fellows of the College, I am pleased to have this opportunity to offer comments on the President's health system reform proposal. Of course, like you, we have only been able to study a draft of the reform plan. We hope to frame our views on the various elements of the proposal more clearly when additional details are made available and all of us have an opportunity to examine it more thoroughly.

The College certainly commends the President for his leadership in proposing steps to bring about reforms to the nation's health care system. We support his call for achieving universal access to health care and for making needed reforms in the insurance marketplace. We also welcome his interest in malpractice reform and administrative simplification, which, in our view, are long overdue. Nevertheless, there are several aspects of the President's plan that are of significant concern to us.

Reorganizing the Health Care System. The President's plan seems to call for a major restructuring of the health care system through the creation of a new and highly bureaucratic scheme. All sorts of new boards, corporations, advisory councils, and other quasi-governmental alliances would be created throughout the country, to carry out activities such as: setting and enforcing global budgets; implementing regulations governing the content of health plans; negotiating fees; managing the post-graduate training of physicians; collecting and disseminating vast amounts of data on health care services and financing; reviewing quality of care; collecting premiums, and so on.

At a time when we should be streamlining our system and reducing the bureaucratic and overhead burdens that drain funds that could be used to provide health care services, we find this very disturbing and fraught with the potential of seriously undermining the public's expectations about our ability to proceed along the path to reform.

The President recently called for "reinventing" government -- for enhancing the efficiency and responsiveness of federal agencies and programs by downsizing and consolidating the extensive federal organization that has evolved to meet the needs of the American people. We believe that the bureaucratic scheme set forth in the President's health reform plan needs to be examined carefully in light of this government reform initiative. Certainly, better ways can be found to achieve the goals of health system reform without resorting to a new and complex regulatory scheme that is so heavily dependent on decisions being made in Washington by a few federal policymakers.

Financing Health Reform. We realize that health system reform will require that new financial resources be invested to achieve the goals of universal access and coverage. However, the College believes the Administration has unrealistic expectations about financing the reform effort through very deep reductions in the Medicare and Medicaid programs, largely through significantly decreased payments to those who now provide health care services to elderly, disabled, and low-income Americans.

We are also concerned that the proposed premium caps could quickly lead many health plans to resort to health care rationing, or face the risk of failing altogether. In fact, it seems likely that adopting health system reforms will stimulate the overall demand for health care services. Yet, the President's financing plan would respond to any increases in consumer demand through further sharp reductions in Medicare and Medicaid, and by imposing premium controls in the private sector.

The Fellows of the College are also very much disturbed by an apparent attempt in the President's plan to address certain "primary care" objectives *at the expense* of other services. For example, it can hardly be considered fair for the Administration to propose paying surgical services less than justified under Medicare's resource-based payment methodology in order to pay more for primary care services than is justified under that same resource-based approach. We understood that this subcommittee and the Congress adopted the resource-based payment system in an effort to establish payment amounts that accurately reflect the work and resources involved in providing physicians' services, adjusted by performance-based volume considerations. In our view, the President's plan would essentially make a sham out of these purported efforts to rationalize the Medicare physician payment system.

Similarly, we think it is inequitable, and even rather odd, for the President to recommend eliminating the 10 percent Medicare payment incentive for surgical and most other physicians' services in *urban* health professional shortage areas in order to double the payment bonus for primary care services that are provided in rural and urban shortage areas.

The College does not take issue with the interests of policymakers to meet the primary care needs of all Americans. However, we do believe that some elements of the President's reform plan seek to achieve that goal in ways that could create potential barriers to the availability of surgical and other kinds of health care services. We hope that Congress will consider carefully the wisdom of trying to finance so much of the reform effort from reduced or redistributed Medicare and Medicaid funds, and from hoped-for savings under an untested and undesirable national premium control program.

Patient Choice. We applaud features in the President's plan that would provide Americans with a choice of at least three different types of health plans, including plans that will allow participants the option of consulting any health care provider, subject to reasonable plan requirements. The American College of Surgeons supports the continuing ability of individuals and families to meet their health care needs through a variety of arrangements. Indeed, we would be very concerned if the President's interest in a so-called managed competition approach to reform effectively limited choice to only one type of health plan, such as a health maintenance organization.

The College believes, however, that more must be known about the design of the health plan options under the President's proposal before decisionmakers can determine if Americans will, in fact, be presented with a reasonable choice of affordable health benefit arrangements, including plans that do not require individuals to seek care through gatekeeper mechanisms.

For example, in the case of the so-called high cost sharing option, which is presumed by the Administration to include plans that do not employ gatekeepers, alliances or states would be expected to negotiate fee schedules and other payment methods for the services provided under those plans. However, if those fees and payments are unreasonably low, as

they are now under the Medicare and Medicaid programs, true freedom of choice in selecting a plan may not exist in some areas, or perhaps exist on paper only. Thus, the College is not convinced that real freedom of choice will be achieved only through defining the benefit and patient cost sharing features of the different options, as the President's plan suggests.

We are pleased to see that, under the Administration's plan, most Medicaid recipients will have the same opportunities as other Americans to make a choice in their health benefit arrangements from among the plans participating in the regional alliances. However, as we see it, these individuals may still have some of their options effectively constrained by the fact that they can only choose a plan that costs the same as, or less than, the weighted average local premium, unless they make an additional payment. Medicaid patients have financial resources that are, by definition, already limited. In reality then, these individuals could be denied real opportunities to enroll in certain plans that would be available to those who have greater financial resources. We hope that any such restrictions on the choices available to Medicaid recipients will not be applied in order that they, too, may enjoy the full range of benefit arrangements offered under health system reform.

Global Budgeting. The College has major concerns regarding the President's proposed global budgeting scheme, which, in our view, concentrates far too much regulatory authority in the hands of government and alliance officials. Under the President's plan, the federal government is responsible for enforcing the health care budget. Based on proposed premiums, the National Health Board would calculate the anticipated weighted average premium for every alliance throughout the United States. If an alliance's weighted premium exceeded its per capita target, "assessments" would be imposed in health plans with premium increases that exceed the alliance's premium target. Moreover, the same assessments could be passed along directly by the plans to the health care providers.

The College understands the importance of including provisions in a reform program that will promote the goal of protecting universal health benefits in cost-effective ways. However, we believe that various incentives should be used instead of regulation to contain costs. These incentives could include marketplace pressures and performance-based methods that make both patients and providers aware of the costs of medical care. For example, the American College of Surgeons has been a strong supporter of policy devices such as expenditure targets, or Medicare volume performance standards, that actually involve physicians and physicians' organizations in the effort to address the annual growth in spending for the services they provide.

However, the President's approach to budgeting is not a performance-based method that involves physicians and other health care providers. Instead, it calls for imposing arbitrary limits on the rates of increase in health spending at the national level and for each regional alliance. Moreover, the budget allocations to the alliances would be established by just the seven unelected individuals who comprise the National Health Board.

We believe strongly that the decisions about how much should be spent on health care in the future in all districts and states represented by Congress should not be left in the hands of these few individuals. Congress must assume a much more direct role in allocating health care resources, if the President's global budgeting mechanism is given any serious consideration. We doubt that the extraordinary diversity in the needs and desires of the American people for affordable, quality health care can be addressed through the rigid kinds of budget controls that are currently outlined in the descriptions we have seen of the Administration's proposal.

Physician Workforce/Graduate Medical Education. Finally, as you know, the College believes that Congress should consider graduate medical education financing and physician workforce issues in conjunction with any long-range health reform plan. We do think it is reasonable to consider a reduction in the total number of residency positions currently available, and to reconsider the rationale for maintaining such a large number of post-graduate positions that are now filled by international medical graduates. The College

believes that establishing specific numerical limits on the number of physicians to be trained may be an effective way for policymakers to determine the future mix and numbers of medical and surgical specialists. In general, the President's reform plan proposes to manage the number of post-graduate training positions and to provide funding directly to the training programs.

The College has taken no position about the precise physician-to-population ratios that would best meet the nation's physician workforce needs, nor have we determined the most appropriate mix of physicians among the medical and surgical specialties. In previous testimony before this committee, we have urged that these goals be established after a more careful assessment is made of the potential implications that health system reform may have on the ways in which medical and surgical services are organized.

However, we are troubled by a provision in the President's plan that would require the Secretary of Health and Human Services to appoint 10 regional councils to allocate training slots among individual residency programs. These government-controlled councils would consist not only of representatives of academic institutions that train physicians in these regions, but also representatives of regional health alliances, health plans, consumers, and others.

Instead, the College believes that, if the Secretary establishes national residency goals (after obtaining any advice she feels necessary), the existing structure of the Residency Review Committees should be given the responsibility for establishing the program criteria that would work best to implement the national physician supply targets. We also believe that the President's proposals for graduate medical education financing should explicitly include a policy of adequate government funding for all residencies through the entire course of the training period. If we commit ourselves to establishing the number of physicians we want to train, it seems only reasonable to support that training for the full residency period.

Again, the College is pleased to have this opportunity to share some of its thoughts on the initial draft of the President's health reform proposal. Obviously, we have commented on only a few items in this proposal, and will undoubtedly be expressing opinions on other elements of the plan as more details are known.

I would be happy to answer any questions you or members of the subcommittee may have.

Chairman STARK. Dr. Coleman

**STATEMENT OF WILLIAM H. COLEMAN, M.D., PH.D.,
PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS**

Dr. COLEMAN. Mr. Chairman, I am Bill Coleman, president of the American Academy of Family Physicians. The AAFP represents 75,000 family doctors, family practice residents and medical students.

We believe the President has submitted a thoughtful and creative blueprint for positive reform of our health care system. The academy is eager to work with the administration, the Congress and other advocates of change to make meaningful reform a reality. When reform legislation is unveiled, the academy is prepared to work with you to hammer out the details, reach the necessary compromises and ensure that lasting health care reform becomes public law in 1994. Our commitment to this great endeavor, like yours, is longstanding and steadfast. In 1989, the academy became the first physician organization to adopt a plan for universal access to comprehensive health care services through a public private effort modeled on the employee-based insurance system. An expanded version of this plan, "Rx for Health: The Family Physicians' Access Plan," was released in 1992.

The academy's reform plan shares many of the ambitious goals and principles found in the September 7 draft of the Clinton plan. These similarities are examined in detail in my written testimony.

While our members have endorsed the principle of the Clinton plan, we have particular concerns with provisions of significance to family physicians that also touch on issues over which this subcommittee has jurisdiction.

First, we are anxious that the suggested method for establishing a per cap baseline premium target for each health alliance could deepen the shortage of family doctors in rural areas. This is because the President continues to use unjustified geographical variations to calculate the premium target, although the cost of practice in rural areas is no lower than that of urban areas. The academy believes the traditional urban-rural differential in payment calculations must be eliminated as part of a larger effort to remedy the shortage of health care providers in rural communities.

As for enforcing the health budget in this new system, the President would impose a penalty or an assessment on each plan whose premium increases surpassed the alliance's inflation factor. The plan is silent, however, regarding the pivotal issue of how a penalty will be apportioned among providers. This omission is troubling.

The plan must be clarified to require that alliances determine the reason premiums exceed the budget target and then to make those providers responsible for the increases pay the assessment.

Turning to the national inflation factor used in the President's draft, we believe that reliance upon the Consumer Price Index may be unrealistic. Several factors influence changes in the need for health care services in ways the CPI cannot accurately measure.

For this reason, the final policy on this matter should recognize scientific advancements, and population and epidemiological trends in determining the annual inflation factor.

Regarding the Medicare section of the plan, the academy certainly appreciates those reforms targeted at increasing payments for primary care services, but it is unclear whether the proposed increases will offset reductions in Medicare expenditures also in the plan. For example, the suggestions to remove volume and intensity from the Medicare volume performance standard and to reduce indirect medical adjustment would be especially harmful to family practice. Removing the volume and intensity from the MVPS formula would undo the positive impact of setting a higher expenditure rate for the growth of primary care. It makes no sense to increase primary care fees to then subject them to artificially low expenditure targets.

Turning to the IME adjustment, the President would offset a reduction in these payments with an add-on payment to academic health centers. This notion offers scant comfort to family medicine since most family practice residencies are affiliated with community hospitals with no financial ties to academic health centers.

Moreover, 40 percent of family practice residency programs are affiliated with institutions in which they are the only residency program. In such cases, IME reductions cannot be cushioned by more lucrative residency programs found in other specialties. The academy therefore urges policymakers to maintain the current IME payment policy as part of the reform package.

Also, while the projected \$124 billion in Medicare savings in this plan will be applied to new prescription drug and long-term care benefits for beneficiaries, we ask that you be sensitive to the fact that these cuts may also have the unintended consequence of reducing beneficiary access to physicians.

Fraud and abuse: Let me say that upcoding and unbundling of procedures to bilk the health care system should be vigorously punished. Practitioners who seek profits in this improper manner injure the profession while squandering millions of taxpayer dollars.

It should be noted, though, that there is questionable disagreement about the utilization of various visit codes between physicians and Medicare carriers. As we interpret the antifraud abuse section of the Clinton plan, it could impose severe penalties on physicians who believe they have submitted the correct codes for services delivered. Steps must be taken to ensure that this situation is not aggravated when, under the new system, doctors are allowed for the first time to code and charge for preventive services.

Appropriate supply of family physicians: We are very pleased that the Clinton draft identifies strategies for achieving a 50/50 split between generalists and specialists. While many offer rhetoric on the need for more generalists, few are willing to take meaningful action.

The strong message currently in the plan regarding the physician work force is absolutely critical. However, this subcommittee considers the means for meeting the demand for primary care services, we ask that these services not be trivialized in the process. I am of course referring to the situation with the OB/GYNs. We understand that OB/GYNs are seeking to be recognized as primary care physicians. A thorough examination of the academy's misgivings over this effort is included in my written statement, sir.

Family physicians understand that women may, by personal preference, choose to have a majority of their female health encounters by OB/GYNs during certain periods of their lives. We support the continued opportunity for women to make that choice, but I cannot emphasize strongly enough that the commonly accepted definition of primary care requires a much broader range of skills and knowledge than those acquired in OB/GYN training.

As defined by the Council on Graduate Medical Education, primary care entails first-contact care of persons with undifferentiated illness, comprehensive care that is not disease, organ nor gender specific, care that is longitudinal in nature, care that includes coordination of other health services.

The role of the health system's gatekeeper is anything but basic. In its fullest sense, primary care includes the assessment and evaluation of all signs and symptoms initially presented by the patient, the management of acute chronic medical conditions, the identification and appropriate referral for conditions requiring specialized care and the provision for health promotion and disease prevention services.

The OB/GYN literature clearly acknowledges the narrow role of OB/GYNs in delivery of primary care as it is commonly defined. It bears repeating here that under the accepted definition, only family physicians, general internists and general pediatricians actually deliver primary care.

As for the sensitive issue of nonphysician providers, the academy finds absolutely no basis in research for the claim that unsupervised, nonphysician providers can deliver the full range of primary care services with physician-like quality.

The subcommittee should be aware that the call for independent practice status for this group comes from a relatively narrow segment of the nonphysician community. If Congress and the administration decide to preempt State and medical practice acts to remove barriers to practice for nonphysician providers, we strongly believe the same policy should be applied to State nursing acts.

As you may already know, many hospitals want to use non-RN staff to perform some patient-care tasks. These efforts have been thwarted by the nursing profession which claims an RN license is necessary to perform many routine bedside duties. To address only one aspect of practice barriers issues would be in our view intellectually inconsistent.

In conclusion, the time has come for comprehensive health system reform. This will be challenging for Congress, the administration, health care providers, businesses of all sizes and consumers. Change, even positive change, is always difficult, but the status quo is no longer acceptable. We will strive together for reform.

The academy believes we must keep our eyes on the prize by recalling the original impetus for reform is universal access to a comprehensive benefits package, the assurance of high-quality care and control of the spiraling health care costs.

Thank you again for the privilege of appearing before you, and I will be pleased to answer any questions.

[The prepared statement follows:]

**TESTIMONY OF WILLIAM H. COLEMAN, M.D., PH.D.
PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS**

I am William H. Coleman, M.D., President of the American Academy of Family Physicians. The Academy is the national medical specialty society representing over 75,000 family physicians, family practice residents and medical students. It is my pleasure to appear before you today to share with you the views of our membership on the critical issue of health system reform.

Background

Since the mid-1980s the issue of universal access to care has been a focal issue for the Academy. At that time, the impetus for national concern was primarily the growing number of uninsured people and their inability to access appropriate care. Studies documented what family physicians have long known, that people who delay seeking medical care have higher morbidity and mortality and are more costly to treat. As the percentage of the GDP spent on health care in this country has escalated, national attention on the problem of access has shifted to an equivalent concern about cost. The American Academy of Family Physicians shares these dual concerns.

In response to our membership's concerns, in 1989 the Academy became the first physician organization to develop a plan for universal access through a public-private effort, building on the current model of employer-based insurance. In April 1992 the Academy released its revised and expanded plan for health reform, *Rx for Health: The Family Physicians' Access Plan*. Permit me to briefly describe the principal elements of this plan. *Rx for Health* calls for universal access to a comprehensive set of benefits, emphasizing preventive services. It builds upon the present employer-based system and requires all employers, including small businesses, to provide insurance to their employees and dependent family members. Employers pay a specific portion of the premium. Employee cost sharing is based on income, with subsidies available. A key element of the Academy's plan calls for each person to have a Personal Physician, who is in one of the generalist specialties (family practice physician, general internal medicine or general pediatrics). Increased cost sharing is incurred if an individual chooses to seek non-emergency subspecialty care without referral from the Personal Physician. *Rx for Health* includes specific strategies for moving toward a physician supply that is a balance between generalists and specialists. Further, it calls for improved quality utilizing practice parameters and malpractice reforms, including caps on noneconomic damages. And, to address spiraling health care costs, it includes stringent cost containment provisions, including the establishment of a National Board with authority to set and enforce global spending targets. Enforcement is targeted specifically to those segments of the health care system responsible for inappropriate spending increases.

Rx for Health was and is the Academy's vision of health care reform. It has formed the basis of our discussions with members of the House and Senate and with the Administration. It is the gold standard against which we will evaluate proposals for reform, and it includes the specific elements that we will seek as you work for enactment of comprehensive reform.

As we strive for this mutual goal, the Academy believes that we must keep in the forefront of the discussion the original impetus for seeking reform -- universal access to a comprehensive benefits package, assurance of high quality care, and control of health care costs. In the following statement, I will comment on and compare its principles with those in *Rx for Health*. I will then highlight those elements of the plan of particular interest to the Academy over which your subcommittee has jurisdiction.

The Clinton Plan

The Academy has had significant interaction with the Administration during the development of the Clinton health plan and is continuing to work with the White House as the final revisions of the plan are being made. We have had the opportunity to review the September 7 draft and have measured it against principles outlined in *Rx for Health*. The Academy commends the President's leadership and initiative in identifying health system reform as a priority issue and

in developing a comprehensive plan. He has demonstrated a willingness to work with consumers, providers, businesses and other organizations invested in health reform and has expressed a commitment to work with the Congress for passage of a comprehensive plan.

Additionally, the work of House and Senate Republicans to study the complex issues and develop legislative proposals is deeply appreciated by the Academy. It is a significant contribution to the debate. The bipartisan effort in Congress to promote positive solutions to problems in our health system is encouraging.

How does the Clinton Plan stack up against principles in *Rx for Health*?

The following is a comparison of the major principles of *Rx for Health* and those included in the Clinton plan. In general, the approaches outlined in the plans are very consistent.

Universal health insurance coverage:

Rx for Health calls for universal health insurance coverage achieved through employer-based plans in combination with state-sponsored public plans that would replace Medicaid and provide coverage for eligible low income individuals and employees of small businesses.

The Clinton plan calls for universal coverage that is employer-based. Medicaid-eligible individuals receive coverage through health alliances, as does the general population. Subsidies are available for those with low incomes. Small businesses pay an amount between 3.5 percent and 7.9 percent of payroll based on the average employee wage. No business will pay more than 7.9 percent of payroll.

Physician specialty distribution:

Rx for Health addresses the shortage of generalist physicians, calling for at least 50 percent generalist physicians, at least half of whom are family physicians, through changes in Medicare GME and incentives for ambulatory-based training.

The Clinton plan also calls for 50 percent primary care physicians (defined as family medicine, general internal medicine and general pediatrics), but does not specify a percentage of family physicians. It takes an aggressive regulatory approach that includes reform of Medicare GME payments.

Basic health benefits:

Basic health benefits in the AAFP plan ensure comprehensive coverage, emphasize prevention, and utilize cost sharing to promote cost-effective delivery of care. *Rx for Health* specifies that self-referral for services not ordered by the personal physician have a higher patient cost-sharing.

The Clinton plan includes a comprehensive benefit package, including preventive services. Provisions for limiting payment for services obtained on self-referral in non-fee-for-service plans are provided. In the mandatory fee-for-service option, the use of a gatekeeper is prohibited.

Cost containment:

Cost-containment in *Rx for Health* includes a national global budget set by a national health commission and enforced, if necessary, by limiting provider payment increases or otherwise controlling expenditures under private and public plans.

The Clinton plan includes a stringent cost containment initiative, but specifies the target rates of increase in the plan itself. It also provides for a National Health Board.

Quality:

Rx for Health calls for quality of care to be protected and enhanced through a variety of reforms and research efforts.

The Clinton plan places significant emphasis on quality and replaces the PRO program with a new Quality Management Program.

Insurance Reform:

Rx for Health calls for insurance reform, including requirements that all health plans be guaranteed issue, guaranteed renewable, and community rated. It ensures the portability of basic health coverage.

The Clinton plan includes all of the above insurance reforms.

Malpractice reform:

Rx for Health calls for comprehensive malpractice reform, including limits on payments for non-economic damages, limits on attorney's fees, elimination of joint and several liability, reduction in awards by the amount of compensation from collateral sources, and structured payment schedules to replace lump sum awards.

The Clinton plan includes an alternative dispute resolution mechanism, certification of merit, limits on attorney's fees, collateral source rules, periodic payment of awards, demonstration projects on enterprise liability, and a pilot program using practice guidelines. There is no cap on non-economic damages.

Medicare:

Rx for Health calls for Medicare beneficiaries to have coverage comparable to the basic benefit package.

The Clinton plan permits states to integrate Medicare beneficiaries into health alliances if they have the same or better coverage as Medicare. After the health alliances are established, individuals have the right to elect to remain in alliances after age 65 and receive the national guaranteed benefits package. Later in this testimony, I will address in detail specific Medicare features in the Clinton plan, and the impact of these proposals on family doctors.

Financing:

Rx for Health finances the plan through a surtax on personal and income tax liabilities, increases the excise tax on alcohol and tobacco products, and taxes as income to employees that portion of employer-paid premiums in excess of the premium needed to provide the basic benefits package.

The Clinton plan includes an increase in the tobacco excise tax and the tax cap, but does not increase income taxes. The plan relies heavily on Medicare savings.

Based on the draft plan and the President's speech to Congress, the Academy applauds the direction and supports the principles and many of the strategies espoused in the Administration's health reform proposal. The draft plan provides a positive framework for considering the many complex issues entailed in health system reform.

From the perspective of this organization, the Clinton plan holds the promise of reforming the health care system in a positive direction. Academy members are particularly pleased with the commitment of the President to universal access to a set of comprehensive benefits that include preventive services and prescription drugs and that provide a good start on mental health coverage. These are services often overlooked in insurance benefit packages. As deliberations on reform continue, these elements must not be compromised. All people in the United States must have access to comprehensive, affordable, high-quality health care services.

I will next address a set of health reform issues that the Academy regards as essential and that we believe will receive consideration in your committee deliberations. My comments focus on budget development and enforcement, the Medicare program, fraud and abuse, malpractice reform, antitrust, achieving an appropriate physician supply, regulatory burdens, and health research.

Budget Development and Enforcement

Alliance Per Capita Baseline Target

The Academy is extremely concerned that the proposed method for establishing a per capita baseline premium target for each alliance will incorporate unjustified historic variation in health care expenditures. Areas with low per capita health spending are typically characterized by poor access to health care resources. In order to rectify the inequitable distribution of health care resources, we strongly recommend the inclusion of explicit provisions calling for the elimination of this unexplained and inappropriate variation.

The per capita baseline target for each alliance is based on the national per capita baseline target adjusted for current regional variations in health care spending and for rates of under- and insurance. Measures of regional variation may include variations in premiums, variations in per capita health spending, variations in per capita Medicare spending, and other factors commonly used by actuaries. A process also is laid out for recommending adjustments in the method of calculating premium targets. An advisory commission to the National Health Board is to explore methods of reducing geographic variation in budget targets due to differences in practice patterns, physician supply, population characteristics, and other factors. Adjustments to targets require Congressional approval.

As you know, family physicians tend to locate their practices in rural areas, and, as a result, have had first-hand experience with the consequences of geographic variation in spending. We believe that the low per capita health care expenditures of rural residents reflect low rates of insurance coverage and the incorporation of historically depressed payment rates into current physician and hospital payment formulas. These low payment rates have persisted despite the fact that the cost of practice is no lower in rural areas than in urban areas. Low rural payment rates are largely responsible for the shortage of health care providers in rural communities. The Academy sought a remedy for these historically low rates in the Medicare physician fee schedule. Unfortunately, we were not successful. The geographic adjustment factor perpetuates the traditional urban-rural differential in payments, and, as a result, the disparity in the supply of physicians between urban and rural communities grows larger.

We understand that minimizing disruption may require that initial premium targets reflect current spending patterns. However, we strongly believe that achieving equity in access across all alliances will require the elimination of all unexplained and inappropriate variation in per capita premium targets. We seek a much stronger commitment to eliminating unwarranted premium variation than is currently in the plan, specifically a requirement that the National Health Board will adjust methods for calculating premium targets in a manner that eliminates unexplained or inappropriate variation in alliance per capita premium targets.

Enforcement of the Budget

According to the draft plan, if an alliance's anticipated weighted-average premium exceeds its per capita budget target, an assessment is imposed on each plan whose premium increase exceeds the alliance's premium inflation factor. Assessments are then imposed on plans and on providers receiving payment from that plan. The language in the plan does not specify how the assessment is to be apportioned among different kinds of providers. This omission causes us great concern. Every effort should be made by plans to determine the reason that the premium exceeds the target and to then make the assessment in accordance with that determination. For example, a thorough analysis should determine whether premium increases are attributable to hospital inpatient days, medical procedures, pharmaceuticals, or other types of services. Assessments should then be made to the providers accountable for the excess premium increases. Otherwise, we are concerned that providers not responsible for inappropriate increases will be assessed the same as other providers and therefore penalized for behavior not their own. A further concern arises in a scenario where provider assessments are determined through negotiation with the plan. Some segments of providers with more experience in negotiation may be placed at an advantage. We therefore urge the inclusion of language that plans make every effort to determine the reason for the premium increase and assess providers in accordance with that determination.

National Inflation Factor

The President's health reform proposal limits the annual growth in premiums to a national inflation factor. The inflation factor in 1996 is specified as the projected increase in the Consumer Price Index (CPI) plus 1.5 percentage points. The inflation factor subsequently decreases in equal increments to reach CPI in 1999 and each year thereafter. We are concerned that the decrease to CPI may be an unrealistically stringent limit on growth in health insurance premiums.

The Academy supports enforceable budgeting for health care expenditures. Family physicians are extremely concerned about the amount of unnecessary, inappropriate and overly-expensive care that is rendered in the American health care system. We have not only supported serious cost containment measures, but we have recommended numerous delivery system reforms that will provide the tools that are necessary to live within a budget without compromising quality.

While there is a great deal of waste in the system, it will not be easy to recapture those wasted dollars and redirect them to improving access and quality, especially in the short run before delivery system reforms have been fully implemented. In the longer term, CPI may still be an unrealistic standard. Some allowance must be made for scientific advancements and improvements in our ability to treat conditions for which remedies do not currently exist. In addition, changes in basic population characteristics, such as immigration, fertility, and aging, and epidemiologic trends, such as an increase in the incidence of AIDS, may bring about changes in the need for health services that are unrelated to CPI. We therefore ask that language be added to the section on annual increases that would allow the National Health Board to recommend adjustments to the national inflation factor in order to allow delivery system reforms to achieve cost-efficiencies and to recognize scientific advancements in the practice of medicine.

Medicare Provisions

The draft plan proposes a variety of targeted measures to increase Medicare payment for primary care services. In addition, a large number of changes are proposed for the Medicare program in order to reduce the growth in Medicare expenditures. Specific cuts of concern are:

- reductions in the IME adjustment,
- deletion of the volume and intensity factor from the MVPS formula (typically seven to eight percentage points),
- establishing cumulative expenditure goals for physician services,

- competitively bidding for all Part B laboratory services (except in rural areas), and
- elimination HPSA bonus payments for non-primary care services.

The inadequacy of Medicare payment for primary care services constitutes a major disincentive for physicians to select primary care specialties and to locate in underserved communities. It is unclear to us that the net effect of the Medicare provisions in the draft plan will result in any appreciable gains for primary care. We believe that the measures to improve primary care reimbursement under Medicare must be substantially strengthened.

Under the Medicare fee schedule, payment for office visits are less than the cost to the physician of providing the services. Based on an extrapolation of Medicare payment rates (using the time values and Medicare fees assigned to visit codes), a primary care physician seeing only Medicare patients would be unable to financially support a practice. In addition, because of the Geographic Adjustment Factor, Medicare payment rates in rural areas are generally below average. This circumstance is well-known and constitutes a major disincentive for young physicians to select primary care residency training and to locate in underserved areas. Although the Medicare physician payment reform provisions passed by Congress in 1989 were supposed to have addressed these issues, problems in the implementation of the fee schedule have all but completely undermined gains due to primary care physicians.

By its nature, family practice is particularly affected by low Medicare payment rates. This is because family physicians tend to locate their practices in rural areas, because the services provided by family physicians are predominantly office visits, and because a relatively high proportion of family physicians' patients are Medicare beneficiaries. There is, therefore, little opportunity for family physicians to compensate for low Medicare rates.

We applaud the Clinton plan's intention to improve reimbursement for primary care physicians. However, it is not apparent whether the proposed increases in primary care payments will substantially offset the other reductions in Medicare expenditures. If Medicare payments are to no longer serve as an impediment to entering primary care, payment rates must immediately increase by 20 to 40 percent. The combination of measures that are necessary to achieve this end is of less consequence than their net effect. For example, while we support the development and implementation of a resource-based practice expense payment method, it will take several years to collect the data necessary for such a method to be introduced. In the mean time, practice expense payments for primary care services should be increased by approximately 20 percent.

Two particular provisions warrant special attention. First, the Medicare Volume Performance Standard for primary care services must accommodate both higher payment rates and appropriate increased in volume. Specifically, we are concerned that removing volume and intensity from the MVPS formula will undo the positive impact of setting a higher expenditure target rate of growth for primary care. It would make little sense to increase primary care fees, only to then subject them to the consequences of artificially low expenditure targets. We urge the Administration in its final draft to set the MVPS for primary care at a level that allows for appropriate growth in expenditures.

Second, the proposed reduction in the indirect medical education adjustment will have a disproportionately negative effect on family practice residency programs. We understand that the draft plan proposes to offset the reduction in IME through an add-on payment to academic health centers. However, most family practice residency programs are affiliated with community hospitals, many of which are not financially affiliated with academic health centers. Moreover, 40 percent of family practice resident programs are affiliated with institutions in which they are the only residency program. For these institutions, reductions in IME payments cannot be cushioned by more lucrative residency programs in other specialties. Although the draft plan creates an all-payer practice residency training fund that is well-targeted on primary care, many of the hospitals with which family practice residency programs are currently affiliated would be inadequately compensated for the indirect costs of graduate medical education. We therefore ask that the reform package maintain IME payments for community hospitals affiliated with family practice residency programs.

It is also worth noting that while the anticipated \$124 billion in Medicare savings will be used to finance the cost of new long-term care and Medicare drug benefits, these cuts may also adversely affect beneficiaries by, for example, reducing access to participating physicians. Once this aspect of the plan becomes more obvious to beneficiaries, the Medicare features of the President's plan are likely to meet stiff opposition from Medicare recipients and their advocates in Congress.

Malpractice Reform

While provisions of the draft plan to address malpractice concerns are consistent with those supported by the Academy, it is silent on two effective strategies that have been utilized in state malpractice reforms: the limit of payments for non-economic damages and a statute of limitations for filing a claim. Additionally, two provisions need to be strengthened. First, the requirement for a Certificate of Merit does not specify that the physician submitting the affidavit be of the same medical specialty and be actually practicing in the field of the defendant physician. We believe this is essential to provide an accurate assessment of whether the physician deviated from the established standard of care. Second, in its present form, the alternative dispute resolution mechanism would add more administrative burden to the resolution of malpractice claims than it would eliminate.

We suggest the following language (both modifications and additions) to the proposals relating to malpractice reform in the draft:

- **Creation of Alternative Dispute Resolution Mechanism** (modification underlined)

Each health plan establishes an alternative-dispute resolution process using one or more of several models developed by the National Health Board. Potential model systems include early offers of settlement, mediation and arbitration.

Consumers who have a claim against a health-care provider are required to submit the claim through the alternative dispute system. At the completion of the alternative dispute system, if one of the parties in the dispute wishes to challenge the outcome of the alternative dispute resolution, he or she may do so in court. If the decision rendered in court is less favorable to him or her than in the alternative dispute resolution, he or she shall pay all legal fees.

- **Requirement for Certificate of Merit** (modification underlined)

Lawsuits claiming injury from medical malpractice include submission of an affidavit signed by a physician of the same medical specialty and practicing in the same medical specialty as the defendant physician. The affidavit must attest that the specialist examined the claim and concluded that medical procedures or treatments that produced the claim deviated from established standards of care.

- **Statute of Limitations** (additional section)

A claim must be filed within two years from the date that the alleged injury should have reasonably been discovered, but in no event more than four years from the time of alleged injury. In the case of alleged injury to children under age six, a claim must be filed within four years from the date that the alleged injury should have reasonably been discovered.

- **Limits on Non-Economic Damages** (additional section)

The plan establishes a \$250,000 limit on non-economic damages, often referred to as "pain and suffering" awards.

Fraud and Abuse

While the Academy supports the effort to eliminate provider initiated fraud and abuse, certain provisions place providers at undue risk, particularly in regard to false claims for deliberate upcoding (see page 174 of September 7 draft). However, there is currently considerable disagreement about the utilization of the various levels of visit codes between physicians and Medicare carriers. Physicians who have performed the services described in the CPT coding manual for a particular level of visit are challenged by carriers and accused of "upcoding." As we interpret this section of the draft, these physicians, who believe they have submitted codes that are consistent with the services provided, would be subjected to assessment of civil monetary penalties.

Another concern relates to preventive services. Physicians have neither coded nor charged for preventive services, because these services currently are not covered. Physicians expect to appropriately code and charge for these services when included in the nationally guaranteed benefits package. We are concerned that physicians charging for previously uncovered services may be subject to charges of "unbundling" and the commensurate civil monetary penalties.

While deliberate upcoding and unbundling should be prohibited, we believe that including these as false claims and subjecting them to severe penalties should be reconsidered in light of current problems with the use of visit codes and potential accusations of unbundling when appropriately coding for newly covered services.

We are also concerned about the provision to toughen penalties for wrongdoers that allow forfeitures of proceeds derived from health care fraud. In view of the above definitions and identified implementation problems, the penalties appear too stringent.

Physicians who now live in fear of inadvertently committing Medicare fraud and abuse will have this fear considerably heightened by the proposed provisions.

Achieving an Appropriate Physician Supply

While much has been said in the past year about the shortage of generalist physicians -- family physicians, general internists and general pediatricians -- the rhetoric is often unmatched with action.

We are particularly pleased that the Clinton plan focuses attention on and identifies specific strategies for achieving a more appropriate balance of generalist and specialist physicians. Physician workforce goals must reflect the health care needs of the population. Correcting the problems of specialty imbalance in the system will require significant changes in current federal policies and aggressive interventions. These efforts are controversial as they challenge the status quo, but are essential if we are to achieve universal access to comprehensive health benefits. This will be one of the most difficult and challenging legislative issues. While many offer rhetoric on the need for more generalists, few are willing to take meaningful action. The strong message currently in the Clinton plan regarding the physician workforce is critically important.

As this committee considers its deliberations on health care reform, the Academy urges its members to address the issue of ensuring a physician supply that is adequate and appropriate to meet the health needs of the population. While grappling with strategies for meeting the demand for primary care services, however, we urge that primary care not be trivialized in the process.

A primary care physician (or generalist physician) provides definitive care to the unselected patient at the point of first contact. Such a physician will have been specifically trained to provide primary care services, usually through completion of a residency in family practice, general internal medicine or general pediatrics.

Primary care physicians devote the substantial majority of their practice to providing primary care services to a defined population of patients. The style of primary care practice is such that

the personal primary care physician serves as the first point of contact for substantially all of the patient's medical and health care needs.

Occasionally, individuals who are not trained as primary care physicians will provide patient care services within the domain of primary care. These limited primary care providers may be physicians from other specialties, nurse practitioners, or physician assistants. Such providers may focus on patient care needs related to prevention, health maintenance, acute care, chronic care of rehabilitation.

The contribution of limited primary care providers may be important to specific patients. However, the absence of a full scope of training in primary care and limited practice skills in providing full primary care services requires that such providers work in close consultation with fully trained primary care physicians. Effective systems of primary care will use limited primary care providers as adjuncts to the health care team with primary care physicians taking responsibility for the total care of each patient.

We understand that obstetrician-gynecologists have sought to be recognized as primary care physicians. The fact that Ob-gyns provide certain services that are within the domain of primary care is well recognized. Furthermore, we recognize that many women have the majority of their health care encounters with Ob-gyns during certain periods of their lives. However, the commonly accepted definition of primary care incorporates a much broader range of skills and knowledge than is present in Ob-gyns. As defined by the Council on Graduate Medical Education, primary care entails first-contact care of persons with undifferentiated illnesses, comprehensive care that is not disease or organ specific, care that is longitudinal in nature, and care that includes the coordination of other health services. In its fullest sense, primary care includes the assessment and evaluation of signs and symptoms initially presented by the patient, the management of acute and chronic medical conditions, the identification and appropriate referral of conditions requiring specialized care, and the provision of health promotion and disease prevention services. While a number of providers receive training in and typically provide some important aspects of primary care, it is only the primary care specialties of family practice, general pediatrics, and general internal medicine that are specifically and fully trained to provide the broad range of primary care competencies. We note that the Ob-gyn literature clearly acknowledges the limited role of Ob-gyns in the provision of primary care.

As the definition of primary care is used in the President's health reform plan, it dictates a substantial redirection of training funds. Because the role of Ob-gyn in primary care is limited, we are very concerned that efforts to improve access to primary care will be compromised by including Ob-gyns in the definition of primary care. Increasing the training funds for Ob-gyns will not substantially improve the number of providers of primary care services. Furthermore, including Ob-gyns in the definition of primary care suggests that there are available many more primary care physicians that is, in fact, the case.

We understand that many women may, by personal preference, choose to have a majority of their female health care from an obstetrician-gynecologist during certain periods of their lives. We support the continued opportunity for women to make that choice. This is clearly an option that will be preserved under the mandatory fee-for-service plans, and we expect that many managed care entities will allow women to utilize Ob-gyns routinely. What is at issue for the Academy is improving access to primary care services. An important part of addressing this issue is training more primary care physicians. We believe this best accomplished by leaving undiluted the current definition of primary care (family medicine, general internal medicine, and general pediatrics).

Prior to reaching a final decision on this issue we would urge each committee member to pose the following questions to the Ob-gyn community:

- What percentage of currently practicing Ob-gyns spend the majority of their clinical practice providing services in the domain of primary care?

- If all Ob-gyns are classified as "primary care providers," how will the Ob-gyn community assure women that a specific Ob-gyn physician is both willing and competent to serve as her primary care physician?
- If Ob-gyn, as a specialty, is classified as "primary care," in what ways and how rapidly will Ob-gyn residencies redirect their training from the current emphasis on surgical specialty training towards the full competencies of primary care providers?

Unless you are satisfied by the answers to these questions that Ob-gyn will truly function as a primary care specialty in the future, we would urge you not to change their specialty designation in the President's plan.

Non-Physician Providers

As the challenge of moving toward an appropriate balance of generalists and specialists in the physician supply is addressed, the related issue of the role of non-physician providers in the health care system emerges.

At a recent meeting of the Academy, Administration officials indicated that the language in the September 7 draft dealing with barriers to the practice of nurse practitioners, nurse midwives, and physician assistants (hereafter referred to as non-physician providers) would possibly be strengthened to include a pre-emption of state laws and regulations deemed to be overly restrictive. We believe that the language contained in the September 7 draft provides sufficient means to address unwarranted barriers to the practice of non-physician providers and, furthermore, the current language avoids unnecessary consequences that would accompany a federal pre-emption. Pre-empting state practice acts would constitute an unwarranted federal intrusion in an area of traditional state jurisdiction and may result in adverse consequences for both the cost and quality of care.

As the plan currently reads, the Secretary of the Department of Health and Human Services is directed to develop and encourage the adoption of model professional practice statutes for advanced practice nurses and physician assistants (see page 130 of the September 7 draft). In addition, an earlier section defining a covered service establishes a standard that prevents any state from limiting the practice of any class of health professionals except as justified by skill and training (see page 21).

No topic that we will address in this testimony presents more difficulty to a physician. We recognize that it is all too easy to read into these words an attempt to simply protect professional "turf." Allow me, therefore, to preface these comments by noting that no other physician specialty is as likely to engage in collaborative practice with non-physician providers. We fully appreciate the substantial contribution of non-physician providers to the delivery of primary care. Furthermore, our members are cognizant of the fact that many state laws impose undue restriction on the practice of non-physician providers. We approach this issue supporting the expanded utilization of non-physician providers and the elimination of undue barriers to their practice.

The substantial abilities of nurses to provide certain high-quality services that are within the domain of primary care is well recognized. However, the commonly accepted definition of primary care incorporates a much broader range of skills and knowledge than is present in any of the non-physician practitioners. While a number of providers receive training in and typically provide some important aspects of primary care, it is only the primary care specialties of family practice, general pediatrics, and general internal medicine that are specifically and fully trained to provide the broad range of primary care competencies. (See also the comments above on obstetrics and gynecology as "primary care physicians.")

We find the call for the unsupervised practice of primary care by non-physician providers unsupported for a number of reasons. First, while generally positive in its findings, the available research on the quality of care and cost-effectiveness of non-physician providers is

limited in the scope of services examined, employs a narrow-range of quality measures, and provides no basis on which to judge the quality and cost-effectiveness of unsupervised practice. All of the studies of which we are aware examined non-physician providers practicing with physician supervision. The claim that unsupervised non-physician providers can provide the full range of primary care services with physician-like quality has absolutely no basis in research.

Second, the Academy notes that the call for independent non-physician provider practice comes from a relatively narrow segment of the non-physician provider community. The physician assistant profession has explicitly rejected independent practice. The non-physician providers with whom family physicians work, especially those who practice in remote settings without on-site supervision, do not consider independent practice to be professionally responsible. They, as well as their patients, need to know that when confronted with a serious or confusing medical condition, a responsible supervising physician is immediately available to provide either consultation or direct intervention. Anything less risks compromise in the quality of care.

If, however, for whatever reason you decide to propose a federal pre-emption of state medical practice acts in order to remove barriers to the practice of non-physician providers, we believe that the same logic and mechanism should be applied to state nursing acts. As you may know, many hospitals have sought to improve efficiency and productivity by utilizing non-RN personnel to provide numerous patient care tasks. These efforts have been frustrated by the nursing profession, which has asserted that an RN's license is required to provide many routine bedside duties. To address only one aspect of this issue of "barriers to practice" in the President's proposal would be intellectually inconsistent.

Regulatory Burdens

The Clinical Laboratory Improvement Amendments (CLIA) regulations are perhaps the most onerous federal requirements presently imposed on family physicians. The level of regulation, expense and exasperation inflicted on small physician office laboratories has no relationship whatever to improvements in patient care or patient safety. The impetus for CLIA '88 was a response to quality problems in large reference laboratories performing Pap tests, not physician office laboratories. However, the resulting law subjects office laboratories to the same level of regulation as reference labs. This makes no sense in terms of quality of patient care, and, in fact, has resulted in reduced access to testing and increased expenses for physicians. As you work to reform the health care system and develop regulatory strategies that improve efficacy and cost-effectiveness, the Academy again urges you to call for repeal of CLIA provisions relating to physician office laboratories and instead concentrate efforts on improving quality of Pap testing.

While the Academy appreciates the initial efforts outlined in the plan to provide a measure of relief from the regulatory burden, practicing family physicians who have reviewed the material are concerned about the stipulations that regulation will continue for labs that engage in critical testing or conduct testing to monitor care while it is being delivered. These provisions will largely undermine the efforts in subsequent sections aimed at easing the regulatory burden on labs performing simple and moderately complex tests. As an inherent component of patient care, family physicians routinely perform lab tests to get immediate results in order to begin appropriate treatment and monitor care while it is being delivered, not dissimilar to physicians who perform microscopic tests. The choice, timing, and interpretation of laboratory tests are integral to a physician's clinical decisions regarding subsequent diagnostic and treatment interventions. Lab procedures are not a separable aspect of clinical medicine. To continue the present regulations in these instances will continue the present unreasonable regulatory burden.

We urge deletion of the requirement for continued regulation of labs engaging in critical testing (a test is critical if an answer is needed quickly or an error can result in serious harm to an individual) or conducting testing to monitor care while it is being delivered.

Other federal regulations also serve only to increase the cost of medical care and the administrative burden on physicians without any measurable benefit to patients. The present

OSHA bloodborne pathogens regulations are a good example. The Centers for Disease Control guidelines for universal precautions are straightforward and afford patent and health professional safety in regard to HIV infection, Hepatitis B, and other diseases. The OSHA regulations, enforced by intimidating OSHA inspectors, are excessive and threatening to physicians. We urge that you call for repeal of this overly burdensome regulation and, instead, acknowledge the appropriateness of the CDC guidelines.

Antitrust

As we read the language in the section entitled "Antitrust Reform," it appears to constitute a restatement of the traditional application of antitrust statute and legal analysis. The Academy believes that traditional antitrust doctrine is unduly restrictive and will prove counterproductive in efforts to realign the incentives of the health care system. We believe that a reexamination of federal antitrust law and enforcement policy as applied in the health care setting is essential if physicians are to participate in the new system in a way that promotes competition and thereby contributes to the delivery of affordable medical services to all our citizens.

The President's proposal contemplates a provider environment in which managed care and other organized plans are likely to provide the lion's share of care. Providers will be expected to work cooperatively under this framework to create entities capable of rendering efficient, cost-effective and quality health care. In order for physicians to fully exercise the responsibilities that they will be expected to assume in the emerging health care system, they must be free to negotiate with health plans on a variety of issues without threat of civil or criminal antitrust actions. The new market will demand that physicians respond collectively in order to respond meaningfully. The Academy seeks assurances that family physicians and other front line providers will be able to respond collectively, without being accused of engaging in price-fixing, boycotts, or the threat of boycotts.

The purpose of anti-trust statute is to ensure meaningful competition among both buyers and sellers of goods and services. To the extent that the President's health care reform plan achieves its goal of moving health care consumers into organized, integrated health plans, the nature of the market for physician services will be fundamentally altered. No longer will physicians be able to charge "what the market will bear" in its pure sense; fees for medical services will be established by large purchasers interposed between physicians and their patients. Physicians providing services under the health benefits package will be constrained in their available market-response -- there is nowhere else they can go to "get a better price," and they cannot balance bill. Thus, physician fees will essentially be "set" by those markets or alliances in which they participate. The courts have begun to recognize that health care providers negotiating with payers face an unusual situation that may legitimate certain collective actions. In particular, they have recognized that when confronted with payers who act as bargaining agents for large groups of consumers who dictate uniform fee schedules -- anathema in a normal competitive market -- collective negotiation is the only means available to physicians to level the bargaining imbalance. It should also be recognized that providers might constructively band together to provide information about and/or negotiate other aspects of their relationships with the plans, such as payment procedures, documentation requirements, referral arrangements, and adjudication methods. Though the courts have recognized that in the context of departure from a normal competitive market, such collective activities are distinguishable from attempts to dictate terms, there is nothing in the President's health plan document that reassures us such case law will be respected.

Moreover, it is not difficult to imagine -- indeed the goal has been explicitly stated -- that the anticipated consolidation of the insurance market will over time leave many areas of the country with a monopsonistic health plan. Given this likelihood, it is absolutely imperative that physicians have some leverage with which to extract and negotiate fair fees. The fee-for-service section of the President's plan already recognizes the legitimacy of permitting collective action by physicians when faced with a single purchaser. However, once again, we see nothing in the document that extends this principle to physician relationships with monopsonistic health plans.

Family physicians are willing to participate in a system with stringent cost controls provided that they have available a meaningful mechanism for responding to purchaser demands that are patently unfair.

Health Research Initiatives

The health research initiative described in the September 7 draft limits new funding for health research to two areas, prevention research and health services research. While these are important, the draft plan omits a highly relevant and to-date largely ignored research area, family practice and primary care research. For the past 30 years, over 95 percent of all medical conditions have been evaluated and treated outside of hospitals. However, the traditional focus of medical education and research has been on medical problems in referred and hospitalized patients. Thus, the training of physicians and the research agenda have focused almost exclusively on inpatient rather than outpatient evaluation and treatment.

Given that the National Institutes of Health has not in the past and does not now include primary care research, and given that the limited resources and other priorities of the Agency for Health Care Policy and Research have precluded all but the most limited attention to it, we believe that it is imperative to identify family practice and primary care research as a priority in health system reform.

The draft plan placed considerable attention on effective strategies to emphasize training of generalist physicians in ambulatory settings to meet the considerable demand for primary care services. However, the research initiatives portion of the plan is deficient in the comparable area of research. We therefore suggest that a third focus for new funding for health research be specified as family practice and primary care research.

Suggested language follows:

- **Family practice and primary care research** related to better assisting the generalist physician in diagnosis and treatment of the undifferentiated patient population treated in the ambulatory care setting.

PRIORITY AREAS FOR FAMILY PRACTICE AND PRIMARY CARE RESEARCH

The Agency for Health Care Policy and Research and/or the National Institutes of Health initiates and expands office-based, community-oriented family practice and primary care research in priority areas including:

- Research to better understand the role of diagnosis in family practice and primary care to assist the generalist physician to evaluate the myriad symptoms of the patient, differentiate self-limited diseases from those requiring ongoing or intensive treatment and initiate effective treatment. The tangible benefits of such research could streamline the diagnostic process, increase accuracy, and reduce the use of expensive and potentially dangerous medical tests.
- Research to improve the effectiveness of medical care as the physician, in collaboration with the patient designs and implements an effective treatment that reconciles the idiosyncracies, preferences and the needs of the patient with the realities of the illness.
- Research to improve access to health care and the cost-effectiveness of care focusing on the role of frontline, generalist physicians."

Conclusion

The time has come for comprehensive health system reform. This will be challenging for the Congress, the Administration, health care providers, businesses, and patients. Change, even positive change, is always difficult. However, the status quo is no longer acceptable. The American Academy of Family Physicians looks forward to working with you to achieve the positive change that we all seek.

I thank you again for this opportunity to appear before you and would be pleased to answer any questions.

Chairman STARK. Thank you.
Dr. Pearson.

**STATEMENT OF HOWARD A. PEARSON, M.D., PRESIDENT,
AMERICAN ACADEMY OF PEDIATRICS**

Dr. PEARSON. Mr. Chairman, I am Howard Pearson, president of the American Academy of Pediatrics. I am here today representing 46,000 members. I am also speaking for other pediatric organizations that represent academic, research and practicing pediatrics.

We support the President's effort to achieve comprehensive health care reform. He has identified many of the elements children need, including a strong emphasis on prevention and primary care, and an unprecedented effort to reach out to the adolescent and often forgotten population.

The Academy of Pediatrics has long been a proponent of health care reform for children. As you know, approximately 12 million children under the age of 21 are uninsured. The historical record simply does not support the contention that if the needs of adults are addressed, the children's needs will also be met.

Over the past 5 years the academy has developed a proposal to ensure access to health care as a right for all children. Congressman Robert Matsui of California is to be complimented for crafting many of the elements of this proposal into legislation, H.R. 727, The Children and Pregnant Women's Health Insurance Act of 1993. While we support comprehensive health care reform for all Americans, H.R. 727 serves as our benchmark by which other health care reform proposals will be measured.

Chairman Stark, let me acknowledge your commitment to children's health reform as illustrated by the introduction of H.R. 2610, The Mediplan Health Care Act of 1993 and H.R. 200.

While the President's proposal has yet to be officially introduced, we support his efforts to put the right elements in place for the health care needs of children. And one of the key principles that we believe must be included, first, guaranteed financial access to health care for all children and all pregnant women. Second, a comprehensive benefits package.

We are pleased to hear the President's emphasis on prevention and primary care. To be certain that the benefit package continues to provide appropriate benefits for children, we feel there should be pediatric representation on national and State boards that are created under health care reform.

Key to any benefits package to address children's needs is an appropriate schedule for the delivery of those benefits and services. A definitive study on such a schedule has been developed by the Maternal and Child Health Bureau and the Health Care Financing Administration. Their report, "The National Guidelines for Health Supervision of Infants, Children and Adolescents," is due out early next year, and I have submitted a recommended schedule which we believe appropriately addresses the health needs of children from that report.

One other key point to make is be certain that children with special health needs receive the coverage they require. Not only for post-acute rehabilitative services, but also extended coverage for services which promote optimal function.

We believe there should be a one-tier system of medical care regardless of initial safeguards. Any one public plan designed primarily for low-income people could evolve into a second-class system of care. Our sad experience in many areas with Medicare demonstrates this truism.

Under the President's draft proposal, parts of Medicaid will be rolled into a new system of health alliances. We must ensure that no child loses benefits they currently have, either during the transition or once they are in a health alliance.

Preexisting exclusion clauses in insurance must be eliminated. More important issues must be addressed.

Health care reform that eliminates financial barriers to needed health care for many children will generate an increased demand for primary care providers. Today pediatricians care for almost 70 percent of children under 5 years of age. We support the reform of graduate medical education to help increase the number of primary care providers—pediatricians, general internists and family practitioners. These should include incentives for medical students, residents and physicians, especially in under-represented minority groups to choose primary care.

The academy encourages the medical home concept for health care reform because it gets to the very heart of the issue of quality. A medical home is a regular and ongoing comprehensive source of health care available around the clock, 365 days a year. It provides preventative care, early treatment of acute diseases and a coordination of care for those with chronic or handicapped conditions. I believe that for children and adolescents, that this medical home is best provided by pediatricians.

We recognize the importance of cost containment in any health care reform proposal. However, we must not compromise our children's health care on the altar of cost.

Finally, we agree with the need for medical liability reform and administrative reform to reduce the backbreaking paperwork of our present system.

We are faced with a historic opportunity to reform our health care system. The President has provided elements to provide all children access to health care. Members and pediatricians of the American Academy of Pediatrics look forward to working with the President, this committee, Congress in general, as health care reform moves through the legislative process.

Thank you.

[The prepared statement and attachment follow:]

**TESTIMONY OF HOWARD A. PEARSON, M.D.
PRESIDENT, AMERICAN ACADEMY OF PEDIATRICS**

Mr. Chairman, members of the Committee, I am Howard Pearson, M.D. President of the American Academy of Pediatrics. I am here today representing 45,000 physician members who are dedicated to the health, safety and well-being of infants, children, adolescents and young adults. Thank you for inviting me to address the important issue of health care reform. For the sake of our nation's children; we must move the debate forward.

REACTION TO PRESIDENT'S PROPOSED DRAFT PLAN:

The American Academy of Pediatrics applauds the President's bold and courageous efforts to achieve comprehensive health care reform. The President has identified the right elements needed to ensure a healthier future for our children, including a strong emphasis on prevention and primary care. The Clinton draft proposal also makes an unprecedented effort to reach out to adolescents, an often forgotten population, to bring them into the health care system where they can get the services and support they need to make responsible health choices.

ACADEMY EFFORTS:

The American Academy of Pediatrics has long been a proponent of health care reform focusing on the health care needs of our nation's children and youth. As you know, of the approximately 37 million Americans who have no health insurance, 11.8 million children under the age of 21 are uninsured. Many have inadequate coverage. They are without adequate insurance coverage for necessary treatment services and for even the most basic care needed to prevent unnecessary disease and death. Still others are "uninsurable" because of preexisting, chronic or recurring conditions. Families with special needs children should not be further burdened with significant concerns about how to finance the critical and often multiple health services needed. For too long, children's lack of health care insurance coverage has been neglected by our society. The record simply does not support the contention that if society takes care of adults, children will be cared for as well. We must not forget our nation's children in this debate.

H.R. 727, "THE CHILDREN AND PREGNANT WOMEN HEALTH INSURANCE ACT OF 1993":

To ensure that the needs of children would be addressed in the health care reform debate, the Academy developed a proposal to essentially establish health care as a right for all children under age 21 and pregnant women. Congressman Robert Matsui (D-CA), turned our proposal into legislative action, reintroducing H.R. 727, "The Children and Pregnant Women Health Insurance Act of 1993" in February of this year. H.R. 727 currently has 27 cosponsors, and we commend Congressman Matsui for his ongoing efforts to speak out for children in this debate. While we support comprehensive health care reform for all Americans, H.R. 727 serves as our benchmark for children's health care, by which the American Academy of Pediatrics will evaluate all other health care reform proposals.

Let me also at this time, salute Chairman Stark of this Subcommittee, for his own demonstrated commitment to children's health care with his introduction of H.R. 2610, "The Mediplan Health Care Act of 1993."

THE PRESIDENT'S PROPOSAL:

The President has demonstrated his serious commitment to address the health care needs of this country's youngest citizens. While his proposal has yet to be officially introduced, judging from his statements, we support his efforts to put the right elements in place for children. This includes a strong emphasis on prevention and primary care; guaranteed access to a one-tier system of care; health insurance reforms that would finally do away with pre-existing conditions, and; a solid basic benefits package, including comprehensive coverage for immunizations.

WHAT CHILDREN NEED:

Key Academy Principles:

Guaranteed financial access to health care for all children (through age 21) and all pregnant women:

We believe all children and pregnant women are entitled to appropriate health care. Their access to such care must be guaranteed. This is the key to health care reform. Yet, sometimes it is forgotten in the debate over the specifics of various plans. The fundamental challenge before us is that, 11.8 million children are uninsured in this country. The President recognized this challenge and addresses it in his plan. The President's proposal will cover all Americans and legal residents. That is a major step. If we agree to nothing else, let us agree that all children must have access to comprehensive health services.

Include a basic, comprehensive benefit package:

The Academy shares the President's call for a mandated, comprehensive benefit package that is spelled-out up front. Without such a mandate, it becomes difficult, if not impossible, to guarantee coverage. If it is not spelled-out up front, we risk the possibility of losing the benefits in the future. We are especially pleased to hear the President's call for a new emphasis on prevention and primary care. Preventive care, the hallmark of pediatric practice, currently is poorly covered by many insurance companies, despite the economic payback and medical efficacy of childhood immunizations, prenatal counseling and care, and screening for anomalies that may prevent or lessen lifetime disability when detected early. The Academy believes that preventive care is critical to any proposal designed to provide a healthier future for our children. Benefits should meet the unique health care needs of children recognizing that children are not "little adults". To ensure that the benefit package continues to provide appropriate benefits for children, there needs to be adequate pediatric representation on all national and state boards created under health care reform. The fact is, whenever the standard

benefit package is finally established, that is probably all that children will get. While adults may purchase supplemental benefits, chances are that children will be left with whatever benefits they get from the standard benefit package.

Key to any benefit package that addresses children's needs, is a timely schedule for the delivery of those benefits and services. I am pleased to report that the definitive study on such a schedule has been developed by the Maternal and Child Health Bureau (MCH) of the U.S. Public Health Service and the Health Care Financing Administration (HCFA). Their report, "The National Guidelines for Health Supervision of Infants, Children and Adolescents" involved over 150 distinguished professionals representing child health and related perspectives, and is due out early next year. This report examined the issue of an appropriate schedule of visits for children in greater detail than any other report, including the much-quoted U.S. Preventive Services Task Force Report, which ironically, never studied this particular issue in depth. In fact, the Chairman of the U.S. Preventive Services Task Force stated that the Task Force Report should not be used as an authoritative recommendation for well-child care visits.

The use of an age-appropriate schedule of visits for delivery of benefits and services to children is critical to achieve the greatest value for the benefits provided. Anticipatory guidance visits, for example, can play a key role in avoiding injuries and disease. The earlier we get the children in for visits, the better chance those children have for a healthy and productive future. It's no coincidence that the MCH/HCFA report I mentioned earlier, is referred to as the "Bright Futures Project". We know what is needed. No more studies are required.

I have attached a recommended schedule which the Academy believes appropriately addresses the health needs of children.

One other key point is to make sure that children with special health needs receive the coverage they require. For example, in addition to post-acute rehabilitative services (as outlined in the President's draft proposal), children also need coverage for rehabilitative services which lead to the establishment of functional capabilities to ensure optimal functioning.

Establish a one-tier system of medical care:

The Academy agrees with the President that we must establish a one-tier system of health care in this country. Regardless of initial safeguards, any public plan designed primarily for low-income people would eventually degenerate into a second-class system of care as the result of inevitable political and economic pressures. Our experience with Medicaid demonstrates this.

Medicaid has perpetuated a two-tiered system of care in which eligibility, benefits and reimbursement limited by lack of funds, vary from state to state. Medicaid still retains a welfare stigma and must be applied for with a means-test administered by the public aid

system. Working class families struggling to stay independent find this aspect of the program distasteful and resist enrolling their children.

The Academy understands that under the President's draft proposal, parts of Medicaid will be rolled into the new system of alliances. While this is an important step in achieving a one-tier system of care, we must ensure that no child loses any benefits they currently have on Medicaid (including Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services) either during the transition, or once they are in an alliance. Also, if health care reform limits the increase in Medicaid funding, we must ensure that children still receive adequate and appropriate funding for the health services they need.

Eliminate pre-existing condition exclusion clauses in insurance:

Pre-existing condition exclusion clauses in insurance represent a serious and unnecessary barrier to care for uninsured children. Uninsurability due to pre-existing medical conditions must be eliminated, and we commend the President for his determination to do that in his draft proposal.

Address workforce issues:

Passage of health care reform may eliminate financial barriers to needed health care for many children and generate an increase in demand for primary care physicians. These children and adolescents will need quality health care, the provision of which can be complex and time consuming. Pediatricians are the most appropriate providers of primary care for infants, children and adolescents. Today, pediatricians provide care for almost 70 percent of children aged 5 years and younger.

The Academy recommends:

- The creation of an independent National Health Care Workforce Commission, insulated from the political process and with broad and balanced representation from the primary care community, including pediatrics, as well as the non-primary care community. Among the activities the Commission would be responsible for are: projecting the aggregate need of the medical care workforce for the health delivery system; determining the necessary number of residency positions on a national basis, including international medical graduates; and allocating residency positions by specialty and subspecialty with regard to medical personnel and population needs.
- The costs of graduate medical education should be shared by all payers;
- Primary care residents should receive total compensation that is equal to or greater than other residency positions in the institution;
- Incentives should be encouraged, both short term and long term, for medical students, residents, and physicians (especially under-represented minority groups) to choose primary care;
- Recognizing that the current supply of allied health care professionals may not be adequate, we support increased training of allied health professionals in primary care.

Ensure Quality:

The Academy encourages the medical home concept for health care reform, because it gets to the very heart of the issue of quality. A medical home is a regular and ongoing comprehensive source of health care, available around the clock, 365 days a year. It provides preventive care, early treatment of acute diseases and the coordination of care for those with chronic or handicapping conditions. I believe that for children and adolescents, this medical home is best provided by pediatricians.

Provide cost containment:

We recognize the importance of cost containment in any health care reform proposal. However, we must not compromise our children's health care. With respect to children, specific cost-containment measures should include the following:

- ▶ An emphasis on preventive care with short term gains, as exemplified by the cost benefits of immunizations, as well as long term gains in early identification and amelioration of chronic disabilities;
- ▶ Targeted, income-adjusted cost-sharing;
- ▶ Delivery of health care services in appropriate sites, such as substituting costly emergency room services with primary care in an office setting and promoting the medical home concept of continuity of care, and;
- ▶ Coordination of care for children with special health care needs.

Specific cost-containment measures with respect to providers include:

- ▶ The development of a pediatric-based relative value scale (RBRVS) Here again, the Academy commends Chairman Stark for his efforts to develop a pediatric RBRVS;
- ▶ Medical liability reform; and,
- ▶ Administrative reform measures.

By expanding access to health care for our children and improving their health, we will not only do what is right, but we will contain costs, help ensure quality and strengthen our economy. It can be done.

CONCLUSION:

We are faced with a historic opportunity to reform our health care system. Literally, millions of uninsured and underinsured lives hang in the balance. Our President has provided the leadership we need. He has provided the elements we need to bring about reform. Providing all children access to health care is the foundation upon which meaningful health care reform will be built. Now we must all shoulder the burden to make sure that children have a voice until the final vote is tallied, and comprehensive health care reform is passed. The 45,000 pediatricians at the American Academy of Pediatrics earnestly look forward to working with the President and this committee as health care reform moves through the legislative process.

Thank you.

TABLE I -- COVERED CLINICAL PREVENTIVE SERVICES *

Age	Immunizations	Tests and Clinician Visits
0-2	4 DTP, 3 OPV, 3-4 HiB, 1 MMR, 3 HBV	11 Clinician visits,** 1 Hereditary/Metabolic Screening, 2 Hematocrit, 2 lead, 2 Urinalysis, 1 Tuberculin Test
3-5	1 DTP, 1 OPV	3 Clinician visits, 1 Tuberculin Test
6-12	1 MMR	5 Clinician visits, 1 Hematocrit, 1 Urinalysis
13-21	1 Td	9 Clinician visits, Pap/pelvic,*** 1 Hematocrit, 1 Tuberculin, 1 Urinalysis

* Based on DHHS National Guidelines for Health Supervision of Infants, Children and Adolescents, 1993

An augmented schedule is recommended for children with chronic illness or disability, those in foster care, those with school problems, those who live in poverty, those in dysfunctional families, those at risk of abuse and/or neglect, those who are experiencing emotional problems, and those at environmental risk. Additional contingency visits should be arranged if major changes such as divorce, remarriage, death, or parental illness occur in the family between regularly scheduled visits.

** Includes one prenatal visit

*** As appropriate

DTP = Diphtheria, tetanus, pertussis vaccine
 OPV = Oral polio vaccine
 HiB = Haemophilus influenzae type B vaccine
 HBV = Hepatitis B vaccine
 MMR = Measles, mumps, rubella vaccine
 Td = Tetanus

Chairman STARK. Thank you.

Perhaps I would just make some comments about items that each of you have touched on in your testimony. I guess all I can say is that I can't believe that whether or not we have health care reform, the drumbeat for malpractice reform goes on. I am one who happens to think it isn't going to be as good as you think, even if one of you wrote the bill.

My guess is that the reality of politics should tell you that the California plan is about as good as you could get, given all the political pressures, and it isn't any better in California than it is in Massachusetts, quite frankly, but you will get it. It will probably be written in the judiciary committees of both bodies, and that is all I can tell you. I am not a lawyer so I can't even begin to get into the nuances of it. I guess I would ask you to talk to your colleagues in California and see if you think it is that much better than it is wherever you are and—but it is coming.

In regards to primary care and/or the decision on which doctors go into which areas, I am sure that every Member of Congress would say, yes, we need more primary care, you know? We need it. I don't think anybody has any idea of how we are going to achieve that, and it would seem, the only way I know, and it may or may not be possible, is to pay primary doctors more, and then I suspect that we will find more, but that doesn't rest very well if we say the only way we are going to do that is to pay other doctors less.

And so I would think that that is an issue that you all are going to have to solve yourselves and you are going to have to figure out among yourselves how you are going to do it, and, as a matter of fact, I should think you would pray that we don't do it and you do do it. I would join you in those prayers to whomever you care to make them.

Rationing. I am afraid that that is not a threat—or a threat that falls on dead ears. I am going to submit to you that we have the worst rationing of any country in the world. We can all pick areas in our neighborhoods where medical care is not provided in this country or it is provided too late and it is certainly not a conscious decision on anybody's part except in Oregon and they voted for rationing. And the only thing that troubles me there, I would support it, say for the fact they are only going to ration on poor people in Oregon.

Now, if all the people from Oregon were in the plan and they decided to stop certain procedures because they ran out of money, I guess that is democracy. But they didn't. They said we are only going to ration to a small group of people, and so I guess we are rationing now on an economic basis rather than a clinical basis, and I am much more comfortable with you rationing than the Internal Revenue Service rationing. I don't know how that will come out, but I don't know as it is an issue that we can deal with.

On the benefits package, save for what I guess I would call routine preventive care, which, again, everybody I think in the Congress thinks is a good idea, I don't know any plan save capitated HMOs. I don't know of any insurance plan, any indemnity plan, that really pays for a lot of routine preventive care. Blue Cross generally doesn't, Medicare doesn't. And so if you set that aside and

stipulate that we should have more routine screening and preventive care, all of the benefit packages I am going to say are identical save one feature, money. Copays, deductibles, they all pretty much provide for getting your appendix out or they all pretty much provide for eye surgery. It is a question of how much the patient pays or how many days of mental health care. But in general, we aren't restricting procedures, and the fights that we will have, I think, on the cost of various benefit packages are pretty much going to be focused not on the services that we will be able to get from you gentlemen, but how much of that each individual pays is their share of a copayment or what their premiums will be.

And so I just suggest that as things that are present in all the plans that are around, and all the plans purport and want to have universal coverage, by that I mean a way to pay for the services and products, and access, which aren't always together. There is a lot of Medicaid coverage but not always a lot of Medicaid access. Those to me are combined, and then we get into how we are going to pay for it and that is really where the cheese starts to bind.

There are a variety of suggestions, and I want to just try this, and you may all know of some others. In general, is it fair to say that ways that we would control costs, professional costs and services from physicians is to set fees. That requires us to worry somewhat about volume and the incentives that Dr. Austen is interested in, possibly a variety of incentives, more fees, bonuses. I don't know what other incentives. Vacations, less paperwork, I don't know, full-time bookkeeper, indentured to you for the life of your practice.

The other is salary and in staff model HMOs. There is some kind of profitsharing, not without its potential risks if the contracts are too procedure specific, but—and that I submit is not popular to the more established practitioners, but may over 10 years become a more popular one, whether we have any legislation or not.

Chairman STARK. Statistics seem to say that the country is going that way, and, well, the third is one that I read into the AMA proposal, which is no restrictions, and the elusive competition will set the limits and also create the rewards. I am skeptical of that one in that I don't know of any area where I could get it empirical enough so I could count it. Maybe you have some others, but I guess I have to ask you the same thing I asked the hospital administrators.

I know that no restriction is the best or the present system whichever you all haven't liked is better. What would each of you suggest to me is the system we could use to reimburse physicians if we had to take something we know, and apply it—Dr. Pearson?

Dr. PEARSON. I suspect that that decision will be made by experts in finance and politics rather than physicians.

Chairman STARK. What would you be happy or least uncomfortable with? I don't suppose you would be happy with anything.

Dr. PEARSON. We could live under any of the alternatives you mentioned as long as the caveat was looked at that it wasn't locking into cement the present inequities of the present system.

Chairman STARK. Would it be easier with one in your practice—if you had eight different systems, would one perforce be simpler for you?

Dr. PEARSON. Obviously the fewer the better.

Dr. GRINER. Let me reflect the College position on this point. Currently our dissatisfaction with the present system is one that basically points out that if one combines price controls with intrusive oversight in order to control volume to achieve predictability of expenditures, it begins to erode and interfere with the normal relationship between patients and physician and is one of the biggest points of dissatisfaction that is turning off people from going into primary care careers.

We strongly support a more comprehensive approach which basically defines a budget, hopefully as decentralized as possible, but a budget that a health plan can work with which assures full services to a defined group of enrollees. The ability of that health plan, with the physicians that are in it and the facilities they use, should decide on the most appropriate distribution of the fixed amount of money so that we may return to the level of autonomy in clinical practice that physicians need.

One important principle that I believe is critical is that we should only hold physicians or health plans, whichever, accountable for costs that they can control. My background by the way is from Rochester, New York where we had and lived under a budgeted plan for hospital reimbursement during the 1980s in a very satisfactory way.

Chairman STARK. I have a question—I want to come back. We will go to Dr. Coleman.

Dr. COLEMAN. Let me preface my answer with two comments. One, I practice in a rural community of north Alabama in solo practice as a family physician. Two, I served on three of the different panels in the development of the RBRVS. If you gave me my choice, the very best system in which you could pay me as a solo would be a true RBRVS system, pay me fairly and adequately for work done, equally for what I do compared to any other subspecialist.

The second point would be to eliminate the difference in rural and urban payments. I have never understood why I get paid one fee for doing the same thing that a doctor does in an urban area 45 to 50 miles away and I can show you and the committee and Congress that my costs and overhead are just as great and in fact I am beginning to suspect are going up faster and higher than my urban counterparts.

Chairman STARK. I happen to agree with you. At least thus far as I have been an observer of this payment system at least for 8 years, 9 years, I can see no pattern for the difference in what you would call the professional component. I guess I could say that if you are a great success in some procedure and you become a superstar, then you can attract some high fees that you might want to live in a nice residential area, but I just cannot—for every time you think you see a pattern, you see something where people are being reimbursed in a different area for the same procedure at another rate.

Dr. COLEMAN. In my small community, we have been trying to get increased primary care providers for the last 7 years.

Chairman STARK. In your small rural community, does anybody pay new beginning family practitioners or GPs on a salary to start?

If I wanted to live there and had just finished my residency, how much could I make to start?

Dr. COLEMAN. That is the comment I was going to make. I have tried to hire on help or another family practitioner for my practice in a rural area. I cannot compete with a hospital based HMO or a large group. In northern Alabama, they hire on at \$100,000, \$120,000 starting that year.

My practice would go broke trying to compete with that, especially for the first year when they are not productive.

Chairman STARK. They would have to pay you something for your equipment or to buy into the real estate?

Dr. COLEMAN. No. I start at 7 a.m. in the morning and quit at 7 p.m. at night. I do 35 or 40 people in the office and take care of my hospital practice and do hospital rounds at night. If you know someone, send them. I promise you they will not have to buy in.

Chairman STARK. They won't get all the bad weekends? You are willing to share the Super Bowl with them?

Dr. COLEMAN. In the group we work in my coming schedule is Thanksgiving Day, Thursday, Friday and Saturday.

Chairman STARK. What you are saying, I don't know if you have been to Germany—it would sound to me like what you are suggesting is that the way they reimburse physicians in Germany, primary care physicians is something like Dr. Griner and you would suggest, is that there is local decisionmaking and there is a very intricate fee schedule but that is it. It is negotiated at a variety of levels.

I will turn to Dr. Austen and say—I couldn't believe what Dr. Todd said, AMA would accept the German model because there—you would be exempt, but every hospital-based physician is paid on salary and cannot practice fee-for-service save the chairman of an academic department who may take fee-for-service patients. If I were an insurance company there, it is one fee per day, whether it is a plantar's wart removal or heart transplant; \$300 a day if you could believe that. All surgeons, et cetera, work for a salary for the hospital.

I didn't even suggest to Dr. Todd that you would introduce that bill for fear I would be pilloried.

Jerry, how do we do it? What reimbursement system—

Dr. AUSTEN. It is not an easy answer. I think I would just say two or three things. One, it seems to me that a fee schedule is the appropriate way to go. I believe that the best way to do that is a negotiated fee schedule that includes physicians in the negotiations. And, as you know, we in the College believe that it should include a performance based incentive system.

Chairman STARK. Yes, we agree. Well, I guess what I sense is that if we are going to write a bill and pass it, I can't believe that there is a hundred votes for any particular plan around here now, and I can't believe that there is any one system if you take the components of a bill that is got a hundred votes in agreement.

So I guess I am stuck with the dilemma of saying I guess we have to put them all in there, which means that we will have a fee structure that will be negotiated somehow. I do not like the idea of a premium and somebody alluded to that, because I can't follow

that down to how we will save money. I can follow it down to how the insurance companies might very well withhold service or do risk selection, but I can't quite see that the incentive is there.

I don't think the insurance companies are going to negotiate with you and get a better fee deal than we could get. I think they understand that the entrance exam to medical school can't be passed with doing the math section with your shoes and socks on and that it is much easier to select risks than it is to chisel you guys so I don't think that will happen.

There will be increased managed systems many of which will have salaries, most of which have fee-for-service. What percentage of the people in Alabama belong to managed care programs, Dr. Coleman?

Dr. COLEMAN. Mr. Stark, I can't give you an exact number.

Chairman STARK. I know it is 3 percent in South Carolina.

Dr. COLEMAN. I said "Gee whiz, he has his facts down already." I would say not more than 5 or 6 percent. We are like most southern States. We don't have that much. You struck a chord when you commented about insurance companies negotiating with us. Something that I did not touch on in my oral testimony that I think is in my written testimony is if we don't have some relief from anti-trust, we can't negotiate.

Chairman STARK. I think you guys as individuals would get a lot of relief. I am not sure that the hospitals and some of the major service providers and corporate entities are going to get off scot-free on that one. If we are going to ask you to negotiate, it seems to me we have to let you talk to each other.

Let me ask Dr. Griner because it is a question I have wanted to ask before, could you give just a quick overview of how the so-called Rochester plan works and whether—how hospitals and doctors are doing under it and what the Clinton plan might do to it.

Dr. GRINER. I will try to be succinct and informative. I referred to the reimbursement plan in effect for the Rochester hospitals during the 1980s which represented a fixed amount of money per year adjusted annually for local wage inflation with a couple of important principles; number one, that a contingency fund was made available to reimburse for unexpected expenses so that the cap was fluid.

Number two, that hospitals were held accountable for costs that they could control, hospitals and their physicians. Excluded for example would be the incremental costs of a large epidemic. That would be retroactively reimbursed. I think that is a terribly important principle for any type of budgeted alternative, whether at the regional or State or Federal level.

During the period of the 1980s under that plan, hospitals and their medical staffs were able to adapt appropriately. The incentive for driving more patients from the system did not exist. The incentive for doing too little also was not realized. We did not see a lowering of the quality of care.

The hospitals financially did as well, actually better than the hospitals in the rest of New York state that were under a charge-based reimbursement system. Currently in New York State in Rochester, as with all regions of the State, we are under an all-payer DRG system which is inherently inflationary.

We are considering the creation of a local commission that would work with hospitals and their medical staffs basically to result in the creation of health plans under a possible local budget that would result in the goal that we mentioned before; a fixed amount of money with some predictability in annual expenditures and leaving it up to the providers to decide on the most equitable distribution of those budgeted funds keeping in mind the fluidity and the contingencies that I referred to earlier.

Chairman STARK. You could become a plan under an alliance.

Dr. GRINER. Exactly.

Chairman STARK. I presume you each either have or do practice in some sort of a, part of your practice in a fee-for-service mode. Obviously you do, Dr. Coleman, and Jerry, I don't know whether you practice outside of teaching?

Dr. AUSTEN. I do.

Chairman STARK. Of the systems that you come into contact with, you don't have to mention by name, that would be Aetna, that would be Blue Cross, that would be Medicare and Medicaid, and it might be—arguably one system without regard to how much you get.

I am talking now about the hassle factor. Is there any one of those systems that stands out in your mind as being significantly easier for you or your staff to deal with? Maybe not. And if not, would then having just one system be significantly easier in terms of reducing the hassle factor?

Dr. PEARSON. I guess our major problem is that although the insurance companies are increasingly using RBRVS in Medicare there is no pediatric RBRVS.

Chairman STARK. We are working on that.

Dr. PEARSON. We thank you.

Chairman STARK. You do? Will that help?

Mr. PEARSON. I think it will help. That is our major deficiency, because then its becomes a negotiated item for something that has no fixed value.

Chairman STARK. You are suggesting that any one system you would be happier, assuming that it is flexible.

Dr. PEARSON. Exactly.

Dr. GRINER. We have in Rochester 65 percent enrollment in managed care among the working population.

Chairman STARK. In one managed care plan or in two plans?

Dr. GRINER. Two; 2,200 physicians, most belong to both plans, so the simplicity factor is there. The key is that the physician groups are able to negotiate an annual budget based on a capitated arrangement and then the physicians themselves become responsible for utilization management and utilization review as opposed to the insurer.

Chairman STARK. You are not all on salary to those plans?

Dr. GRINER. No. There is a capitation that represents the budget that physicians have for the year to use for physician services and then a fee-for-service arrangement is negotiated—is underlying.

Chairman STARK. Within your own group?

Dr. GRINER. Yes.

Chairman STARK. So you, not the insurance company, deal with Jerry for surgery?

Dr. GRINER. Yes.

Chairman STARK. And you make that arrangement internally.

Dr. GRINER. That is right. That provides flexibility.

Chairman STARK. Does either system have a significant difference in the review and the simplicity of forms or is it a Hobson's choice there?

Dr. GRINER. The two IPA model HMOs are independent and their systems are not compatible. That is an area that we need to work on.

Chairman STARK. Is any one better than the other?

Dr. GRINER. I don't think so.

Dr. COLEMAN. That is a question I have a problem with because from a rural area I don't work any in a closed panel HMO. Blue Cross and Blue Shield PPO for the State of Alabama is my largest payer.

Chairman STARK. So you are dealing for the most part with them?

Dr. COLEMAN. For the most part I am dealing with them, so my experience is PPO, preferred provider type. The answer I can give you is you mentioned hassle factor. What would relieve things for me outside of a closed panel system would be uniform forms, uniform billing. I personally, not speaking academy policy, but as a practicing physician, I personally would like to be able to deal with one entity, not have multiple things.

I do realize that we have to face quality assurance, quality care and I think there has to be some form to do that, whether it can be done through a loose PPO or through a more closed system. I cannot give you specific answers because I personally lack experience, sir.

Chairman STARK. For the specialties.

Dr. AUSTEN. I can only speak about what I know in my own area of Boston and Massachusetts. We have—well specifically, I have to deal with two HMOs, two PPOs—

Chairman STARK. Fee-for-service, IPA-type HMOs. You are on a fee relationship?

Dr. AUSTEN. They are fee-for-service that is correct; two PPOs and literally countless private insurance carriers as well as Medicare and Medicaid. They are all different as you know in terms of their requirements, their paperwork and their restrictions. So I think we would all agree that anything that can be done to decrease the paperwork and, very importantly, to decrease the restrictions would be very important to do. And, specific to this question, clearly one payer would help in that a great deal.

Chairman STARK. Well, I keep thinking that the best I could probably sell the medical fraternity would be—I don't know if you are all familiar with the Maryland system for hospitals, and that is that each hospital gets its own fees which are negotiated through a complex system, but it is a negotiation and it takes into account a variety of location costs and so forth. But then once the hospital has that fee, once you are determined that for a specific surgical procedure that is your fee, you have to charge that to all comers. I presume also it allows you to use a single form and a single quality review procedure and everything else.

Would all of you be comfortable without committing to how you would negotiate, if we had a system that would set the basis for a structure within which we could then find a way to negotiate fees, salaries or whatever? I really haven't been able to think of any other way.

There are some who would say we should go to a complete single payer, single system and I don't—I have always thought theoretically true capitation is probably the most efficient economic model. It is the only way I know that you can budget and you can do it all. It isn't going to happen in this country with our political system for the next decade and I am not sure we would get a universal single payer system through. I think we might be able to work to everybody's advantage with some kind of a structure in which we have some room for insurance companies and salaried structures, the Rochester plan to go.

Are you comfortable with that notion?

Dr. COLEMAN. Mr. Stark, I would be comfortable with it if I could have some way of knowing that it would be a fair and appropriate negotiated fee. You have to understand where I am coming from now is dealing with the insurance companies or dealing with a PPO or IPA that says "We are going to reduce you by 20 percent." That is the way we start, or if the negotiating authority such as Medicare says "This is the fee," then I don't know whether I can economically manage my small business, which is what my practice is, and take care of my patients and the quality that I want them to have.

The key there, I have to turn to the question back and say how can we be sure that that fee is going to be a fee that is workable?

Chairman STARK. I have a hunch it will be workable. I am not sure that everybody will like it. We ran into the situation in California, I guess, where we got a normal delivery down to \$600. Even I could figure out that that didn't seem fair to me. I knew what they were charging in the neighborhood, and at some point we corrected that.

Maybe if the fee was \$1,800 in the community, we got at least for Medicaid up to \$1,200. I say OK you have to swallow that much because this is the indigent population. I don't like the ideas. I think if the procedure has a value we ought to find out. I understand practitioners who say I get \$26 to make a house call and the visiting nurse gets \$72.

On the face of it that doesn't sound fair to me. Maybe the nurse has to bathe the person and cook their dinner and all you have to do is pat them on the head and say, "You are looking better. Take an aspirin and leave." I have a hunch that the House calls will still get made. If the pressure builds and if we have a process that you are comfortable with, the taxpayers are comfortable with or the insured, it will evolve.

I don't know how we are doing yet. How are we doing for those of you who deal with Medicare?

Dr. Pearson, you don't very often.

Dr. PEARSON. No, I do.

Chairman STARK. How is it working? It isn't going to work unless you all participate and unless we can find a system is it?

Dr. PEARSON. It works in some States and some areas where reimbursement is fair by the sort of criteria you said. The slogan our profession often uses to describe Medicaid—

Chairman STARK. Medicaid I don't think works worth sour applies now. That is a good reason—I say, do you want State regulation or Federal regulation. I say do you want Medicaid or Medicare? I don't have to count the votes on that one.

Dr. PEARSON. Not applicable.

Chairman STARK. Dr. Griner what is your opinion?

Dr. GRINER. I think Medicare works well for patients. It achieves the goal that was laid out for the population. Medicare's drawbacks are the administrative complexities it the patients complain of; it's intrusive nature with respect to the involvement of physicians in the system, and it has major inequities from the standpoint of the distribution of reimbursement for physician services as we heard before with which I agree.

I believe that Medicare does not need to be dismantled. I believe it can be made more simple by beginning to fold the Medicare population into regionalized systems of health care where reimbursement and organization of health services take account of the unique geography of the region.

Chairman STARK. Do you think that we can make it work by adjusting and—do you think from what you have observed in the negotiations and the problems we have had, whether it has been the EKG issue or whether it has been cutting primary care and paying the surgeons more or not—as you observe the system in its infancy do you think it is going to survive?

Dr. GRINER. The Medicare system?

Chairman STARK. Yes.

Dr. GRINER. The short answer is yes. I believe we need to be folding Medicare into a single organizational system.

Chairman STARK. You don't have to help doctor McDermott that much.

Mr. McDERMOTT. He stopped one word short.

Chairman STARK. You should have been around.

Dr. GRINER. I was not necessarily referring to the payment side of the equation, sir.

Chairman STARK. Dr. Coleman, are you giving up on us?

Dr. COLEMAN. Let me answer that question two ways. I am not giving up on you and the academy isn't giving up on you, but a lot of rural family physicians are giving up on you. Our members are not seeing Medicare patients because they just can't meet their overhead. I am not talking about the doctor taking home money; I mean overhead to pay their employees.

The Medicare system I agree has been good for the Medicare recipients, but I think it lacks in that it doesn't pay for those preventive and primary care services that we are looking at now that I hope Congress looks at for us. Rural physicians have the urban-rural differential under Medicare, the so-called gypsies, and they are not reimbursed properly and as a result they are leaving. Rural family physicians are going to the big cities.

I hate to keep coming back to the same subject but RBRVS—it was a good system, but HCFA and Medicare didn't use it properly and therefore the so-called benefits for primary care and rural phy-

sicians never materialized. I cannot see in rural Alabama that we had gains, yet our overhead keeps going up. I feel somewhat trapped in the system but yet the system is needed.

I need that for my rural patients.

Chairman STARK. I guess I don't want to get into it, but we are in the throes of trying to correct that in the sense that our rather arbitrary distinction between what is professional vis-a-vis what is overhead may be causing that problem. In other words, all I can say is that if I told you we had a solution—and we don't, but to me solving your overhead reimbursement as compared to Jerry's, which is quite frankly some of the specialists tend to stand and perhaps take a hit, some of the primary guys tend to get smart. That is something that we learned in cost accounting courses.

It is an argument about rent, cost of equipment and a whole host of things that—where I am willing to talk about—I don't know anything about the professional side of your practice at all, a little bit about how much it costs to keep books and how much it costs to buy typewriters and equipment supplies, those sorts of things. I think if we can correct that then I hope that we can solve some of that problem for you.

Jerry, it is all your fault.

Dr. AUSTEN. I am used to being accused of that. I would say that the Medicare system is OK. It certainly in our view ought to continue. As with other physicians, our membership continues to be concerned about adequate payment. Their overhead goes up also and their fee structure as you know has, relative to other areas, gone down over the last few years.

The one point that I would make is that, specifically related to the rural area, we in surgery have a similar kind of problem in terms of attracting and retaining surgeons—particularly general surgeons, of course—to practice in the rural community.

Chairman STARK. Unless they want to be circuit riders and just ride the circuit.

Dr. AUSTEN. Yes.

Chairman STARK. I would think it would be very difficult.

Dr. McDermott.

Mr. McDERMOTT. Thank you, Mr. Chairman. I came back because I hoped that you would still be here so I could ask a question that I am puzzled about when I think about the concept of everybody in the United States being in managed care and the concept of gatekeepers or primary care physicians that when you recognize the disproportionate number of specialists we have in this country as opposed to primary care physicians.

I would like to hear you talk about how you think the most effective way would be to get to a condition of having enough primary care physicians to actually staff a system in this country where we would have a requirement or a systematic way of sending everybody through a primary care physician before they are referred to a specialist, and then to what extent you think that would make the system better or worse or what problems it creates.

It is a kind of open-ended question, but I think when people talk about managed care it is like we will just go out and pick a bunch of family care physicians off a tree and we will plug them in and then the system will start up. You and I know that is not true.

I want to know how you see the transition and what ways we can involved in making that happen.

Dr. PEARSON. I will speak with respect to pediatrics. We have addressed that successfully.

Mr. McDERMOTT. Do you think of yourselves as primary care physicians?

Dr. PEARSON. No. Our subspecialists have been through 3 years of pediatric training and have 3 years primary care training before they become a hematologist, like I am.

Mr. McDERMOTT. If a mother comes in with a child—

Dr. PEARSON. I would hope the child would be seen by a general pediatrician.

Mr. McDERMOTT. First.

Dr. PEARSON. That is how it happens now in large measure. Only about 15 percent of pediatricians are subspecialists in hematology or oncology and we are in part capped by the relative small size of the pediatric population. There are nearly 6,000 cases of cancer in children in the whole country in a year. Even if all our pediatricians wanted to be oncologists, they couldn't.

We have strong emphasis on primary care and realization that the subspecialty training is built on that.

Mr. McDERMOTT. Does the society allocate the slots for how many pediatric oncologists and pediatric hematology—does the society decide across the country?

Dr. PEARSON. In an indirect way, by saying this limited number of patients, you don't need very many people, and people don't hire you. We have people who take 2 or 3 years of specialty training, can't find a job and go into primary pediatrics. We have insisted that everyone start with general training so that going back to it is no great difficulty.

Dr. GRINER. Citing figures that you are familiar with, only 12 percent of graduating medical students are entering tracks that will result in them coming out of the pipeline in primary care. We would suggest a combination of incentives and environmental factors along with, if you will, cautious regulatory oversight. Specifically for adult medical practice, we would want to make sure that the environment of medical practice is improved to more equitably reflect the cost and the value of primary care services on the reimbursement side.

We would do everything possible to see legislation that would reduce the hassle that is at the root of so much of the dissatisfaction by the physician that provides primary care today, whether it is clerical, in the interests of oversight or whatever. We would foster the organization of health services into larger units wherever possible so that physicians could begin to modulate the extraordinary costs of solo practice so that larger groups, multispecialty groups would be promoted.

We would support the change of the experiences at the front end, that is to say the mix of students being accepted into medical school, the curriculum of medical education and the mentors those students are exposed to at the beginning of their clinical experiences. We would then promote the overlay of those environmental factors and incentives by supporting the creation of a Federal health manpower plan through an appropriate commission which

would have some level of authority for the ultimate decisions with regard to the number and mix of training programs.

But it would need to be done in ways that are carefully thought out, hopefully with the active participation of those that are involved in medical education and those that are currently involved in credentialing for quality residency programs and some specialty training programs.

Mr. McDERMOTT. When you say alter the early experiences, I presume you are talking about in the first couple of years of medical school, the people with whom you have contact to build them as models for people?

Dr. GRINER. Absolutely. We wish to have students exposed to physicians that are in the real world of medical practice. Surveys that the College has done have shown that the vast majority of internists and family practitioners continue to be professionally satisfied and challenged in the roles that they play.

Many medical students never see that. They see only the narrow perspective of the small proportion of the total population that end up being in hospitals. We promote out of hospital experiences and much more involvement in the curriculum of medical students by practicing physicians.

Mr. McDERMOTT. You are talking about the model used within the program in Washington, Alaska and Idaho placing them with real physicians?

Dr. GRINER. We have the same in Rochester. Fifty percent of the student experiences are with physicians who are in a community-based or rural practice.

Mr. McDERMOTT. That means half of their junior year is spent—

Dr. GRINER. Fifty percent of the physicians that are involved in the education of medical students are community-based physicians so we see students in the various off site settings. Half of the clinical experiences are not there, but there is a major role for those ideal role models.

Mr. McDERMOTT. You didn't mention medical education costs. Is that a deliberate oversight or have you as a group not thought about it, what that does to the incentivizing of behavior, to create a word? What is the average debt at the University of Rochester?

Dr. GRINER. Mr. McDermott, \$50,000 is the average debt. There are recently published data that suggest that career decisions are made largely on factors other than personal debt. We can make those available if you like. It gets back to the point I made earlier about the practice environment as being a greater determinant. We support the unlinking of graduate medical education funding from payment to hospitals.

We support an all-payer contribution to the cost of graduate medical education. We do think that hospitals need to be reimbursed for the indirect costs of GME which have been inappropriately considered educational costs but which actually reimburse hospitals for unique costs that relate to the unique role that they play.

Dr. COLEMAN. I appreciate an opportunity—earlier in my comments I supported strongly from the academy standpoint the portion of the Clinton plan that deals with creating a 50/50 mix. There has been a lot of rhetoric in the past, but no action.

There are three areas. One, that is premed. We have to get to the premed counselors in college and have them talk about family care, internal medicine as good career choices. We are going to gain status and money situations to individuals who want to go to med school because they want to take care of people. So we have to begin the work in the premed at College levels and we need your help.

We have to then concentrate on the medical schools. They have to redirect their activities. They are not here to train or the super technical fee individuals and to turn out 50 percent research individuals. They are here to train the physicians that we need to serve the people.

The first thing they have to do is I think you have to put pressure on the medical school to reorient. They have to be the ones to do new ways to recruit students who would then choose my primary care specialties. They have to figure out ways to evaluate them. If an individual is selected into med school and that individual came from a rural community, they are more likely to go back.

If their wife comes from a rural community or they marry someone from a rural community they are more likely to go back. If they are older when they go to med school they are more likely to choose family practice, more than 50 percent. The age and—as you said, if their debt is lower or if they have some way of repaying that debt such as loan forgiveness from a rural community who is going to help them with their debt, they tend to go back, and once they practice there, they tend to stay.

The other is not what you were talking about earlier, the medical student preceptor programs, but we are beginning to develop preceptor programs where I have had in my practice two premed—I think we need programs where they are exposed at that level.

Mr. McDERMOTT. This is a summer program?

Dr. COLEMAN. Premed, when they are out of college. The one I had was a quarter and it was during the winter. Once they enter school, med school, there are two factors that have been research proven. If a medical school has a family practice department, they have a higher percentage of students who choose family practice.

If they have a required third-year clerkship, more choose family practice. If they rotate, as you heard briefly with a practitioner, a practicing family physician, those schools will have a larger percentage of people who will choose family practice.

I have taken you from premed to med. The final thing is when you graduate, reimbursement has to be adjusted. You can't send them through and then say if you will go out there in Podunk, La., you are going to make half what you make if you stay in an urban area. So we have to adjust that.

I think Mr. Stark and you both, I think had a part in getting us changed where we now pay the new physicians the same when they go into practice. That was a great step forward. If we can take that a step further and get those better payments for primary care so even if they run up a debt, they know they can put it out.

Another point, it is an interesting point. If your medical student is the son or daughter of a physician, they tend not to go into family practice. If they are the son or daughter of a nurse or a psychol-

ogist or someone working in service of the community, they tend to go into family practice.

Those are just some of the facts that we have begun to develop through surveys. My three points are you have to start with premed, follow with acceptance to med school and early on intervention in med school through the third year, and the last is adequate and fair reimbursement.

Dr. AUSTEN. The time is late so I will be brief and I will concentrate on physician training and just indicate that the college has supported a physician work force plan. We think that it would be reasonable to limit the number of trainee positions at some modest percentage higher than the number of graduates from U.S. medical schools.

We think there should be a decision made in terms of apportioning the physicians to be trained among the specialty categories. We feel quite strongly that the primary indication as to where the trainee should be placed ought to be on the basis of program quality, and we believe that there should be full payment for all approved training positions.

Finally, I would say that one of the problems we have is the number of individuals who take their primary training, but then go on to specialty training because of the rather large number of specialty training options available in this country. That is true in surgery and certainly is true in the nonsurgical areas.

Perhaps general surgery does not qualify as a primary care specialty. However, general surgery is an area that we feel quite strongly about in terms of the fact that we probably do not have enough general surgeons, and a physician work force plan would address this issue.

Mr. McDERMOTT. You and Dr. Griner both talked about a Federal manpower plan. I think of my military days—Colonel Perry set up an allocation of how many surgeons and pediatricians and gynecologists they will need each year and they gave you deferments.

Are you speaking about that same kind of plan where at the Federal level you decide that the United States needs next year 10,000 or another 1,000 general surgeons and we will allocate 1,000 residencies to the best hospitals in the country?

Dr. AUSTEN. In a way I would presume that this could be done on a more even keel basis in terms of the numbers, but indeed it seems to me that one of the important things that this country needs to do is decide on the approximate number of individuals out there doing the various things in medicine. And, I must say, we feel that it is going to be very hard to accomplish that by any means other than controlling the opportunities available for individuals to train in the specific areas.

Dr. PEARSON. We would support it too except for the fact that the database upon which such a decision would be made today is flawed. Until there are better data—for example a government report 10 years ago predicted that by 1990 there would be a glut of pediatricians in the country. This has not occurred.

We have shortages. I think that we would support it if we could be confident that the database that these kinds of decisions were made on were solid. We don't have them now.

Mr. McDERMOTT. Thank you, Mr. Chairman.

Chairman STARK. I want to thank all of you, particularly—Dr. Griner had to catch a plane—for your willingness to come here and help us wrestle with this problem. I am sure we will be seeing each other more over the year and your willingness to explore alternate situations and speculate with us how we might come to a solution on this will take a lot of compromise and it has been a pleasure working with you in the past.

I think we will have an exciting year ahead of us and look forward to working with you. Thank you very much for participating with us today.

Our final panel includes three witnesses representing provider groups: Jack Harris is the president of the American Dental Association; Ernest Burch represents the American Physical Therapy Association; Hope Foster is the general counsel of the American Clinical Laboratory Association.

Welcome to the witnesses. The committee thanks them for their patience and I ask them to proceed in the order they were called.

Dr. Harris, do you want to lead off?

STATEMENT OF JACK HARRIS, D.D.S., PRESIDENT, AMERICAN DENTAL ASSOCIATION

Dr. HARRIS. Thank you, Mr. Chairman, Dr. McDermott. My name is Jack Harris, I am president of the American Dental Association, and I would like to thank you for the opportunity of allowing me to appear today before you.

Rather than simply summarize the written statement that we have given you, I would like to take this opportunity to describe to you what we think is a success story, and that success story is the dental care delivery financing system.

It has been my experience in many meetings like this that our policymakers maybe are a little unfamiliar with two key facts, and those are that the dental care delivery and financing systems have been singularly effective in controlling costs and that dental systems are very different from their medical counterparts.

Many of the market-based cost containment mechanisms reformers are seeking to install in the health care system as a whole are already present in dentistry. Dentistry has long stressed the importance of prevention through dental education, preventive treatment modalities, and fluoridation of public water systems. Treatment modalities such as routine oral exams, cleanings and applications of fluoride and sealants are standard.

The dental profession also encourages employers to emphasize preventive care in their dental plans by covering 100 percent of the cost of diagnostic and preventive care procedures. As a direct result of fluoridation, half of today's school children have never experienced dental decay. In fact, this is one area where governmental intervention might very well help us because then we could expand the number of fluoridated water supplies in this country from about 50 percent to the 100 percent that we need.

Our profession already employs a gatekeeper method which assists the patient in developing cost-conscious treatment, because approximately 83 percent of all dentists are primary care providers. The unique design of dental benefit plans has resulted in stability and moderation in the escalation of dental care costs. Through pa-

tient cost-sharing and enhanced provider competition, annual maximums, patient copayments, deductibles and limitation on the type or frequency of treatment ensure that patients will share in their dental expenditures.

All these factors enhance competition among providers, and along with utilization review, contribute to accountability.

Finally, expansion of the current system also has the added advantage of maintaining patient freedom of choice. Our association strongly opposes the taxation of health benefits, especially dental benefits as it would have an immediate adverse impact on all these very successful programs. Oral health care delivery and financing systems are very different from their medical counterparts and they should remain separate and distinct. Dental plans are really prepayment programs, unlike the insurance plans that provide medical coverage. Dental costs are highly predictable, and dental expenditures are relatively modest compared to many medical procedures, so a freestanding dental benefits plan is an attractive benefits package for many employers. When offered within a larger medical benefits package, however, dental benefits are often the first to go in times of fiscal difficulties.

We are concerned, though, for those who cannot afford our services, since the total public dollars for dentistry from all sources is less than \$2 billion annually. To provide access for those who cannot afford coverage, the ADA believes that the Federal Government should provide comprehensive dental benefits for all poor Americans, regardless of age, through an expansion of the restructured, privately administered Medicaid program. The working poor should be provided assistance on a sliding scale based on family income.

In addition, we recommend a formulation of dental health care purchasing cooperatives to allow small businesses and individuals to economically purchase benefits. We are concerned that the administration's proposal, which provides dental benefits based on age rather than need, will result in two things.

One, many Medicaid recipients, especially adults, will lose the dental coverage they now have; and many of the tens of millions of young Americans who are now fully covered with a fine dental program perhaps may have less coverage, because it will be scaled back to be a preventive program only.

So, in closing, I would like to say that the association is looking forward to working with you, Mr. Chairman, and you, Dr. McDermott, and all the Members of the subcommittee in your continued efforts to revise the health system. Although our written statement focuses on the administration's plan, we recognize that there are many innovative plans that Congress is considering; and we hope to work with all of you to devise the best solution for the American public.

Thank you, sir.

[The prepared statement follows:]

**TESTIMONY OF JACK HARRIS, D.D.S.
PRESIDENT, AMERICAN DENTAL ASSOCIATION**

The American Dental Association (ADA or Association), representative of approximately 140,000 dentists nationwide, is very pleased to have been offered the opportunity to appear before the Health Subcommittee of the Committee on Ways and Means to comment on the Clinton Administration's health system reform proposal, with emphasis on oral health care from the Association's perspective.

The Association supports reform of the health care system and clearly states that all Americans should have access to quality health care. We embrace the call for reform to provide security, cost-savings, simplicity, quality, responsibility and choice. We believe that all employers, even small business people such as dentists, should provide catastrophic and preventative medical health care coverage to their employees, as long as they are permitted five years to comply and are provided with adequate offsetting tax incentives.

For dental care - the Association supports maintaining the current private dental care delivery system and focusing the government's responsibility on providing benefits for the population that needs it most -- those individuals without an income and those with a low income -- regardless of age. The Association believes that the American public will be better served by an expansion of the private dental benefits system which contains many of the market-based, cost-containment mechanisms reformers are proposing to instill in the medical delivery and financing systems.

ORAL HEALTH CARE

Oral health is an integral and essential component of total health care. Access to basic oral health care for all Americans is this Association's goal. The ADA believes that access to quality dental care is affected by the manner in which the care is delivered and financed, and we believe that the current delivery and financing systems work very well for those with access. As a result, enhanced access to quality care can best be accomplished by expanding the existing dental care delivery model, with federal financial assistance for special population needs.

First, We Want To Preserve The Current Oral Health Care System.

Oral health care delivery and financing systems are very different from their medical counterparts, and they should remain separate and distinct. Dental plans, unlike most medical plans, are not insurance plans in the truest sense of the word. They are prepayment plans. Dental costs are highly predictable and dental expenditures are relatively modest compared to many medical procedures, so a free-standing dental benefits plan is an attractive benefits package for many employers. When offered within a larger medical benefits package, however, dental benefits are often the first to go in times of fiscal difficulties.

The key concepts that underlie our approach have been developed to expand upon those aspects of our dental care system that have been successful and cost efficient, and to add to our system features that will remove any remaining barriers to seeking appropriate and timely dental care.

The current oral health care delivery system in the United States exemplifies many of the market-based, cost-containment mechanisms reformers are seeking to install in the health care system as a whole - prevention, accountability, competition, use of the "gatekeeper" concept and patient sensitivity to cost.

Dentistry has long stressed the importance of prevention, both as a means of providing the best care to our patients and as a means of containing costs. Dental education, treatment modalities and fluoridation of public water systems are examples of effective preventive measures.

Dental disease is preventable, but the disease will not improve without treatment. The result of inadequate treatment is unnecessary suffering and considerable loss of productivity. The Association supports a variety of dental education programs for children and others, making patients aware of personal habits which promote oral health. In addition, education is necessary to enhance the perceived value of seeking timely dental care, including preventive care.

Treatment modalities, including routine oral exams, cleanings and applications of fluoride and sealants, are standard. Furthermore, the dental profession encourages employers to emphasize preventive care in their dental plans by covering 100% of the cost of diagnostic and preventive care procedures.

Finally, organized dentistry's support for public water fluoridation demonstrates the profession's concern for the public welfare, as few professions have done as much as the dental profession in promoting a public policy position without regard to the financial impact on its members. As a direct result of fluoridation, half of today's school children have never experienced dental decay, according to a 1988 study conducted by the National Institute of Dental Research (NIDR).

The "gatekeeper" concept has been adopted by many of those who wanted to change the health care system as a means of controlling rising costs in medicine. As we understand the concept, a general practitioner would be the first to see patients who seek services from a given health care program. Patients are, in turn, referred to specialists by the generalists.

Dentistry already employs a "gatekeeper" concept, which assists the patient in developing cost-conscious treatment. Unnecessary referrals to specialists rarely occur because approximately 81% of all dentists are general practitioners. The generalists will refer cases to specialists only as necessary.

Dental patients have traditionally shared in the cost of their treatment, so patient sensitivity to price increases is a significant aspect of cost-containment in the delivery of dental care. This aspect enhances competition among providers and, along with utilization review, contributes to accountability.

As detailed above, dentistry has an impressive and effective record of advocating the prevention of dental disease. As a result of our efforts, the incidence of dental disease is decreasing in the United States, as evidenced by recent epidemiological studies. Still, however, the incidence of dental disease remains too high in identifiable segments of the public which lack access or fail to seek treatment.

The delivery of oral health care under the current system has been cost-efficient and effective for those who have access to the system. Protecting and enhancing the financing of oral health care, through the use of private benefit plans, is equally important. The unique design of dental benefits plans has resulted in stability and moderation in the escalation of dental care costs, through patient cost-sharing and enhanced provider competition.

In the United States, only 4% of the money spent for dental care is public money, the rest comes from the private sector. Private sector dental benefits plans directly provide about 45% of the funds spent for dental care. Indirectly, private plans account for even more money currently spent because of patient participation in the costs of treatment.

Encouragement of expansion of the private dental benefits market would capitalize on these advantages and not require a transfer of the \$36 billion spent annually for dental care in the

private sector to the public sector. Expansion of the current system also has the advantage of maintaining provider choice. Other systems which put limitations on the freedom of patients to choose the dentist from whom they will receive dental care will result in the disruption of excellent and long-standing doctor/patient relationships.

The Association's position that the American public would be better served by an expansion of the private dental benefits system and not by inclusion of the dental delivery and financing systems in a medical reform package is supported by experiences outside the United States. If the United States experience is the same as that observed in other countries where universal access to medical care has been accomplished, private employment-based dental benefits will expand to cover a greater portion of the public without the expenditure of additional public money. For example, in Canada there was great expansion of the private dental benefits system following the institution of universal hospital-medical-surgical insurance. In order for this to occur, however, the tax deductibility of dental benefits must be retained.

The Association very strongly opposes any imposition of a tax on dental benefits under any circumstance as it would undermine the current delivery and financing systems. Ensuring the viability of existing dental benefit plans and encouraging their expansion is necessary if we are to continue to improve the country's oral health.

Taxation of health benefits, either directly or by removal of current tax exemptions, will greatly harm private dental benefits plans, as individuals will use their tax-free benefits to protect their hospital-medical-surgical insurance plans and elect not to maintain their dental benefits plans. In addition, employers will be reluctant to continue to provide dental benefits plans when the costs for these plans are not considered a business expense. When faced with the prospect of paying an increased amount of money towards their health insurance costs, employees, especially during these difficult economic times, will elect to forego their dental benefits plan and take the money formerly allocated to their dental plan as increased wages.

Consider these facts: Studies conducted by the NIDR indicate that there is a clear correlation between coverage and improved oral health. In addition, the Rand Corporation and the Congressional Budget Office concluded that dental coverage would be reduced if health benefits were taxed. We must conclude, therefore, that it would be unwise to tax dental coverage if the goal is to improve oral health.

The Second Point of The ADA's Position Is The Need To Take Care Of Special Populations.

The second strategy for the ADA is to underscore this fact and to advocate that the first priority of the government is to focus limited resources to those individuals with the greatest need, regardless of age.

The Association believes additional federal government funding will be necessary in certain instances if more comprehensive access is to be realized. Currently, only children in indigent families are required by federal mandate to have comprehensive dental care provided to them. We believe that all indigent individuals, as defined by the federal poverty index, regardless of age, should have access to comprehensive dental care, preferably through the private insurance industry in a public-private cooperative effort. The benefits of this program should be uniform throughout the United States, as should patient eligibility.

Federal assistance for the working poor and others to purchase dental benefits should be provided on a sliding scale based on family income, and dental health care purchasing cooperatives, similar to the proposed health care purchasing groups, should be established to allow small businesses and individuals to purchase dental benefits more economically.

The ADA strongly supports the principle that all children should have access to basic preventive dental care services. Indeed, we have been working with the Clinton Administration to assure that its definition of preventive services is an adequate one. We stress that preventive services for children should include sealants and simple restorations.

Having said this, we also know that any health reform plan will provide only limited funds to cover dental care. For this reason, we have urged that structuring care by age does not work for dentistry. Children of families with dental insurance already have coverage. Children in families with no coverage but adequate incomes already see the dentist and get care.

We are strong advocates that children from families with no income or low income should be the top priority for a government structured program. And we are very concerned that as the Administration's program seems to be headed now, many Medicaid recipients over 18 will only get the benefits provided in the core package and will, therefore, lose their dental coverage. Furthermore, for low income individuals over 18, even those who may be employed, there are no adult dental services under the Clinton plan. And these are the very people who need it most. Therefore, under the present Clinton plan, poor people will lose many of the dental benefits they have now.

If the Medicare program is expanded to include dental coverage for senior citizens, there should be a defined dental benefit plan enacted to serve the needs of this population group, particularly those that are home-bound or reside in long-term care facilities.

The Association also believes that there should be no discrimination by degree of provider if treatment is provided by a legally qualified dentist or physician operating within the scope of his/her training and licensure. In addition, medical plans must clearly indicate that medically necessary adjunctive care is available to the patient, which is essential to the successful treatment of a medical condition being treated by a multi-disciplinary health care team. Finally, the Association believes financial incentives, such as loan forgiveness, should be established to enhance access to underserved areas.

HEALTH SYSTEM REFORM PROPOSALS

Clinton Administration's Plan:

The ADA appreciates the considerable time, effort and political capital the Clinton Administration has invested in the development of a comprehensive reform package for the United States health system. While the Association does not agree with all aspects of the proposal, we recognize that the President has provided a great service merely by raising health system reform to the level of a major domestic policy objective.

We agree with a basic market-based approach, but not the heavily regulated form of "managed competition" proposed by the Administration. The Health Alliances have too much power to regulate and, thereby, dictate to the American public the kind of delivery systems to be offered. Many of these decisions are best left to the marketplace.

The Association disagrees with the imposition of a global budget. Artificially established budgets will eventually undermine the innovative and creative nature of the health care system in the United States. Furthermore, there is no need for global budgets for dental care financing systems because such plans typically have annual maximums, which when viewed collectively act as a de facto global budget with one important distinction -- maximums are determined by the payers, not artificially established by the government.

We are pleased that the Administration provides some financial relief to small businesses who would have an obligation to provide health care coverage to their employees under the Clinton plan. However, we believe the average wage limitation of \$24,000 is too low and the 7.9% cap is too high to provide needed relief to small businesses with a predominately professional staff.

The Association is encouraged that the Administration offers antitrust relief, but that relief is focused on providers in regulated networks. This approach will not give dentists, who are overwhelmingly solo practitioners, the latitude necessary to continue to offer quality dental care in the manner which has proven to be effective and efficient. It will also result in two antitrust systems (one for care provided in regulated networks and one for market-based care outside the regulated networks) even though market pressures will likely result in changes for providers in both systems. The changes should apply to all providers, regardless of whether they are in a regulated network and should offer greater flexibility for providers who seek to form their own Independent Practice Associations.

The ADA would also like to see stronger tort reform with a ceiling on non-economic damages, more meaningful ceilings on attorneys' fees, and a shortened statute of limitations on health care related injuries. While more information about outcomes is needed to determine more effective and efficient ways of providing care, the Association strongly disagrees with the Administration's suggestion that Data Bank information be made available to the public.

The Association agrees with the Administration's requirement for patient cost-sharing and insurance industry reforms, such as portability of health plans, the elimination of pre-existing conditions, etc.

Addressing a problem discussed in most health system reform plans, the Administration also calls for the reform of Medicaid. The Association supports the Administration's effort to reform Medicaid, but we are concerned that the proposal would provide fewer dental benefits for Medicaid beneficiaries. The proposal incorporates the Medicaid program into the general health care system and provides only those services in the basic benefits package.

Inasmuch as the President's proposal includes only preventive services for children under the age of 18, poor adults will no longer have access to oral health care services. The Association urges a separately administered and delivered dental benefits program under Medicaid, which would be fully funded by the federal government to ensure uniformity of benefits and to provide adequate fee reimbursement for practitioners who provide services to the poor.

The ADA is encouraged by the Administration's acknowledgement of the importance of dental benefits by including preventive services for children in its basic benefits package. As discussed in greater detail above, the Association believes a different approach from the Administration's proposal should be taken, however. The ADA's position is that all individuals without an

income or with a low income, regardless of age, should be provided with government assistance to obtain dental coverage.

The Association believes that no health benefits should be taxed. In particular, dental benefits should not be taxed because the rationale for taxing benefits outside the basic package (i.e. to discourage the buying of "cadillac" plans) does not apply to dental benefits, which are basic benefits, needed to sustain good oral health. As an initial step, the Association is encouraged by the provision of a safe harbor tax exemption for services outside the basic benefits package. We believe the Administration's 10-year safe harbor tax exemption is a step in the right direction, but we disagree with the January 1, 1993 cutoff, as it would undermine the necessary expansion of dental benefits plans. As described below, the Association believes it is imperative that such a safe harbor be provided if dental benefits plans are to remain viable.

**Mediplan Health Care Act of 1993 (HR 2610,
Representative Stark):**

As characterized by you, Mr. Chairman, this bill uses a Medicare-for-all model. A national health budget would be established. Providers would be reimbursed using Medicare's current reimbursement methodologies and additional revenues would be raised through a new 10% tax on gross payments received for Mediplan benefits by providers.

As stated above, the Association does not support global health budgets. In addition, the cost containment mechanisms used in this bill which provides for an expansion of the Relative Value Resource Based System (RVRBS) presently used in Medicare would be unacceptable to the ADA. As noted above, this position is not taken on principle alone but with the knowledge that dental plans, through the use of annual maximums, already operate under a global budget collectively determined by the payers.

SUMMARY

The Association believes it is better to maintain the private dental care system with its simplicity, cost-effectiveness and emphasis on primary and preventive care. To accomplish this objective, it is necessary to retain the tax deductibility of private dental benefits plans.

The Association also wants to ensure that the people who do not have access to dental care because they cannot afford it are helped by the government -- indeed that it is the responsibility of the government -- to provide real comprehensive dental benefits to the Medicaid population and to the working poor on a sliding scale basis. The Association is concerned that the reform of Medicaid under the Administration's proposal would provide fewer dental benefits for Medicaid beneficiaries, especially poor adults. The Association urges a separately administered and delivered dental benefits program under Medicaid, fully funded by the federal government to ensure uniformity of benefits and adequate reimbursement for providers.

The ADA agrees with the basic market-based approach taken by the Administration regarding health system reform but believes the Health Alliances have too much power. A global budget undermines innovation and is unnecessary for dental care financing systems which often use annual maximums. The financial relief for small businesses with professional staffs is insufficient. While the Association is encouraged by the Administration's recognition of a

need for tort reform and antitrust relief, more needs to be done in those areas than the Administration's plan suggests. Finally, the ADA agrees with the requirements for patient cost-sharing and insurance industry reform.

Chairman STARK. Mr. Burch.

STATEMENT OF ERNEST BURCH, P.T., BURCH, RHOADS & LOOMIS, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, ON BEHALF OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION

Mr. BURCH. Chairman Stark, Dr. McDermott, obviously I am a physical therapist, not a speech pathologist, or I would be a little bit better at this.

My name is Ernie Burch. I am a practicing physical therapist, and I am chairman, CEO of Burch, Rhoads & Loomis, a Maryland-based physical therapy firm; and I am here representing the American Physical Therapy Association today. The American Physical Therapy Association is the national association representing over 59,000 physical therapists, physical therapist assistants and students of physical therapy. APTA shares the desire of the American public, other health providers, and our political leaders to make health services more accessible, less costly and more effective for all Americans.

Physical therapists are an integral part of the health care delivery system, providing services to a wide spectrum of patients in a variety of settings from prenatal care to newborns to older Americans, and from community centers to large teaching hospitals. The benefits of rehabilitation and physical therapy services are well documented and services are covered in nearly all Federal, State and private insurance plans.

The APTA has followed the development of President Clinton's health care reform plan with great interest. As the national association representing health care deliverers in a profession whose focus is wellness, rehabilitation and the maximal use of an individual's functional capacities, we are encouraged by the numerous steps being proposed to expand access, enhance quality, and improve cost-effectiveness within our health care system. In that vein then, I will address certain areas that are of specific interest to us. You have written testimony that goes into these in more detail.

The first is access. Individuals should have access to care that promotes good health and protects against disease and injury. According to the National Institute on Disability and Rehabilitation Research. Digest of Data on Persons with Disabilities: 1992, an estimated 40 million Americans live with some form of disability. Currently, there are nearly 6 million noninstitutionalized people over 65 who have physical impairments. Timely access to appropriate care is crucial for these individuals; without it, the costs incurred from repeated institutionalization, remedial care for continued deterioration, loss of job productivity and wage-earning ability, and the increased need for assistance in daily living will continue to skyrocket.

The health reform plan of the future must remove the statutory, reimbursement and other policy and procedural barriers that limit a needy individual's access to rehabilitative care. In this regard, close scrutiny must be made of the workings of the managed care systems that emphasize cost containment at the expense of access to needed services. The health reform system that Congress adopts

must ensure that the access to needed care, especially rehabilitative care, is not blocked by the craving for short-term cost savings.

Likewise, a viable health reform plan must pay careful attention to the treatment of chronic and congenital conditions. For example, half of the estimated 5.2 million individuals disabled by low back pain are chronically disabled. Low back pain is the most common cause of disability among the population under 45 years of age and the third most important cause of disability in the population over 45 years of age.

Viable health reform must include ready access to physical therapists for treatment of chronic conditions such as back pain.

Congenital conditions, moreover, such as cystic fibrosis, also require access to timely rehabilitative care. The appropriate intervention of physical therapists and other rehabilitative care providers can decrease morbidity in the treatment of these conditions.

Prevention is a key. The APTA believes that, based on the experiences of major employers and insurers, it is possible to define affordable limits on a package of preventive physical therapy services that will save many times the cost of such services. Despite a well-defined package of clinical preventive services, the President's plan does not focus on preventive approaches to musculoskeletal conditions determined through such procedures as scoliosis screening or posture evaluation. Nor does the plan identify the cardiac and pulmonary preventive care provided by physical therapists and others through exercise training, conditioning, and consumer education. These aspects of preventive care must be emphasized much more strongly.

The APTA also firmly believes that an emphasis must be placed on work related preventive services. Currently a major focus of worker's compensation programs is an emphasis on functional outcome and injury prevention. The fiscal incentives of worker's compensation insurers and employers are prevention and early return to work, to save indemnity payments and increase employee productivity. However, work-related preventive services are not among the services mandated in President Clinton's plan. Unless this oversight is corrected, a major element underpinning worker's compensation will be completely undermined.

In the time remaining, let me summarize my comments on four other areas.

Education. Health reform must include mechanisms for providing financial support to educational institutions and individuals in professions such as physical therapy where personnel shortages have been identified.

Research. Research dollars should be allocated to support innovation in health care and the development of effective outcome measurements.

Self-referral. Although much progress has been made in limiting the proliferation of self-referral investment ventures by physicians, the failure to address self-referral as present in employment within the physician's office is a very serious oversight. Health reform legislation must close this loophole.

And last, freedom of choice. We strongly support the rights of individuals to choose their health care providers. To this end, we support maintaining a fee-for-service option. We also strongly urge

protection of every qualified provider's right to practice in both managed care and fee-for-service systems.

The American Physical Therapy Association commends you for your dedication to reform of our health care system and thanks you for this opportunity to testify before you.

Chairman STARK. Thank you.

[The prepared statement follows:]

**TESTIMONY OF ERNEST BURCH, P.T.
REPRESENTATIVE, AMERICAN PHYSICAL THERAPY ASSOCIATION**

Chairman Stark, Congressman Thomas, Members of the Ways and Means Health Subcommittee, my name is Ernie Burch. I am a physical therapist and a member of the American Physical Therapy Association. The APTA is the national association representing over 59,000 physical therapists, physical therapist assistants and students of physical therapy. APTA shares the desire of the American public, other health care providers and our political leaders to make health services more accessible, less costly and more effective for all Americans. The APTA applauds our political leaders for their commitment to reforming our health care system.

Physical therapists are an integral part of the health care delivery system. Physical therapists provide services to a wide spectrum of patients in a variety of settings from prenatal care to newborns to older Americans and from community centers to large teaching hospitals. The benefits of rehabilitation and physical therapy services are well documented and services are covered in nearly all federal, state and private insurance plans. Physical therapy services are among the most cost effective health services because a limited course of physical therapy often shortens a hospital stay, prevents future injury, and improves health outcomes. Physical therapists help 900,000 individuals daily to restore health and alleviate pain. Today's physical therapy profession serves a dynamic comprehensive health care role in improving and maintaining the quality of life for millions of Americans.

The American Physical Therapy Association has followed the development of President Clinton's health care reform plan with great interest. We have provided input to the policymakers at every point possible. As the national association representing health care deliverers in a profession whose focus is wellness, rehabilitation and the maximal use of an individual's functional capabilities, we are encouraged by the numerous steps being proposed to expand access, enhance quality, and improve cost effectiveness within our health care system. In that vein then, I will address certain areas of specific interest to us.

ACCESS

Individuals should have access to care that promotes good health and protects against disease and injury. According to the National Institute on Disability and Rehabilitation Research (Digest of Data on Persons with Disabilities: 1992) and estimated 40 million Americans live with some form of disability. Currently, there are nearly 6 million non-institutionalized people over 65 who have physical impairments. Timely access to appropriate care is crucial for these individuals. Without it, the costs incurred from repeated institutionalization, remedial care for continued deterioration, loss of job productivity and wage earning ability, and increased need for assistance in daily living will continue to skyrocket.

The health reform plan of the future must remove the statutory, reimbursement, and other policy and procedural barriers that limit a needy individual's access to rehabilitative care. In this regard, close scrutiny must be made of the workings of managed care systems that emphasize cost containment at the expense of access to needed service. The health reform system that Congress adopts must ensure that the access to needed care, especially rehabilitative care, is not blocked by the craving for short term cost savings.

Likewise a viable health reform plan must pay careful attention to the treatment of chronic and congenital conditions. For example, half of the estimated 5.2 million individuals disabled by low-back pain are chronically disabled. Low back pain is the most common cause of disability among the population under age 45 years and the third most important cause in the population over 45 years of age. The majority of back injuries are job related. Physical therapy is widely viewed as a most cost effective care for both preventing and alleviating low back problems. Viable health reform must include ready access to physical therapists for treatment of chronic conditions such as low back pain.

Congenital conditions, moreover, such as cystic fibrosis, also require access to timely rehabilitative care. The appropriate intervention of physical therapists and other rehabilitative care providers can decrease morbidity in the treatment of these conditions.

PREVENTION

The cost effectiveness of physical therapy programs which prevent disability in the work place is well documented. According to the Washington Business Group on Health, physical therapist intervention resulted in the following savings for some major corporate employers:

Coors	\$604,000 total net saving;
Potomac Electric	\$500,000 yearly;
Lockheed	\$105,000 yearly;
Westmoreland Coal	\$53,130 yearly;
Mississippi Power	\$45,000 yearly;

The APTA believes that based on the experiences of major employers and insurers, it is possible to define affordable limits on a package of preventive physical therapy services that will save many times the cost of such services.

Despite a well-defined package of clinical preventive services, the President's plan does not focus on preventive approaches to musculo-skeletal conditions determined through such procedures as scoliosis screening or posture evaluation. Nor does the plan identify the cardiac and pulmonary preventive care provided by physical therapists and others through exercise training/conditioning and consumer education. Preventive care must be emphasized much more strongly.

Similarly, in the President's plan, coverage for therapy services would be continued so long as recovery is documented. Important as this is, it fails to recognize the value of maintaining patients who have plateaued at a maximum level of function. If these patients are denied access to continuing care, they revert to a condition where acute and more costly interventions are required.

The American Physical Therapy Association believes that an emphasis must be placed on work related preventive services. Currently, a major focus of workers' compensation programs is an emphasis on functional outcome and injury prevention. The fiscal incentives of workers' compensation insurers and employers are prevention and early return-to-work, to save indemnity payments and increase employee productivity. However, work-related preventive services, are not among the services mandated. Unless this oversight is corrected, a major element underpinning workers' compensation will be completely undermined.

EDUCATION

It is universally acknowledged that in sharp contrast to certain other health professions there is a serious shortage of physical therapists.

Health care reform efforts should focus on providing access for consumers to highly qualified health care professions and increase support of activities which would provide greater number of these skilled providers in those professions that have been experiencing shortages. Without an adequate number of clinicians, health care reform cannot begin to ensure the necessary scope, quality, and access to care. Financial support for education should be available on a basis broad enough to attract individuals from culturally diverse backgrounds. Support must be evenly extended beyond the traditional professions of medicine and nursing.

Those professions, such as physical therapy, that are experiencing a shortage of faculty members and clinicians must receive funding to support expansion of the educational system and access of increased numbers of qualified candidates to matriculate into the system.

The President's efforts to expand the current National Health Service Corps model are commendable, but we caution that to make it a successful venture, it must include those health care professions that have been experiencing shortages.

We applaud the increase focus of the plan on the supply of non-physician health professionals and we welcome the outreach to underrepresented population groups. We especially appreciate the inclusion of primary care loans for "students in nursing and targeted allied health professions".

We are concerned, however, with the pervasive singling out of disciplines such as nurse practitioners and physician assistants for priority treatment. While we begrudge none of these groups or the support being offered, we believe a more constructive approach would be to target support of disciplines based on their demonstrated shortage in the health care delivery system.

Along these same lines we urge that the support extended to physicians for the purpose of graduate medical education be extended to non-physician health professionals as well. The loan forgiveness program for medical students should not be available only to medical students. The incentives that are being proposed for these specific groups should be available to a broader range of practitioners based on the demonstrated need for their services.

RESEARCH

Advances in health care for current and future generations of Americans are achieved through systematic study of the nature of disease, the effectiveness of treatments, and the impact of moderating variables that affect the health care outcome. Allocation of research dollars should support innovation in health care, assist in attracting intellectually inquisitive individuals to the health care professions, and foster dissemination of new knowledge to the benefit of the consumer.

SELF REFERRAL

We are encouraged by the proposed prohibitions on physician self-referral. It is our firm belief that the restrictions enacted recently by Congress to the Medicare and Medicaid programs should be applied broadly to the entire spectrum of health care delivery. It is our equally firm belief, however, that these restrictions fall far short of the mark as a comprehensive and long-rang solution to the problem.

The current restriction prohibits self-referral in investment situations on the one hand, but encourage the continuation of the very same practice within the physicians' office. We are very concerned that the proposed health reform plan would take no steps to remedy this situation.

In fact, it appears that the President's proposal would actually erode the progress which is being made to eliminate self-referral. The encouragements of physician networks and joint ventures with hospitals is likely to add serious complication to the problem of self-referral.

FREEDOM-OF-CHOICE

We appreciate the fact that a fee for service option figures prominently in the proposal. We believe that freedom in the choice of their health care providers is important to many Americans. We question the extent to which this option will be viable in the long range, however. Aside from the disincentives in the nature of higher premiums and copayments for a fee-for-service mode of delivery, questions are raised about the opportunity that various health professionals will have to contract with individual health plans. To the extent that this is restricted, so too will be consumer's freedom-of-choice. We believe that health plans should be required to contract with qualified providers.

The American Physical Therapy Association commends you for your dedication to reform of our health care system. We look forward to working with you to create a system in which all Americans receive access to quality, effective care. The time has come for us to unite as a nation of friends. Our political leaders, health care professionals and Americans alike must begin to take responsibility for the health and future of our nation. By working together we will earn respect and confidence which can overcome any obstacle and can bring us towards the mutual goal of obtaining an optimal, working health care system.

Thank you.

Chairman STARK. Hope.

**STATEMENT OF HOPE S. FOSTER, GENERAL COUNSEL,
AMERICAN CLINICAL LABORATORY ASSOCIATION**

Ms. FOSTER. Thank you, Mr. Chairman, Dr. McDermott. My name is Hope Foster. I am the general counsel of the American Clinical Laboratory Association, which consists of federally regulated, independent clinical laboratories that provide testing services throughout the United States.

ACLA is pleased to be here today to comment on health care reform and its impact on the laboratory industry, especially because we have frequently come before you to urge enactment of legislation to significantly reform the manner in which laboratory testing is delivered.

Earlier this year, ACLA adopted its own health reform plan which we presented to you during your consideration of OBRA 1993. In crafting our reform plan for laboratories, ACLA was guided by three overriding principles. First, the plan should promote a more cost-conscious and efficient health care system.

Second, it should ensure that all patients have access to high-quality laboratory testing; and third, it should simplify the rules and procedures that govern the system.

ACLA's plan is a comprehensive program and will only achieve its goals if all of its components are adopted. In our testimony today, we would like to explain how our proposal will help achieve the goals set out above. I will begin with our first one, the promotion of a cost-conscious and efficient system.

To achieve this goal, ACLA would rely on the rules that this subcommittee has already developed to reduce laboratory utilization and costs in the Medicare program. Several of these provisions, including Medicare's direct billing mandate and system of payment caps, have worked well for the program and should be extended to other payers. In our view, a primary reason that the system is in need of reform is that these safeguards have only been applied to Medicare. They need to be extended to all payers.

The centerpiece of the ACLA plan is the enactment of a Federal law mandating direct billing of laboratory services. Such a mandate would require that the laboratory that performs the testing bill the patient or insurer for those services. This provision would simplify the structure of the industry and lead to a more rational and efficient market for testing services. Direct billing would be required by H.R. 200, Chairman Stark's bill, and by S. 337, a measure introduced earlier this year in the Senate by Senators Jeff Bingaman and Howard Metzenbaum. Adoption of such a requirement would promote a more cost-conscious and efficient system for delivery of test services than currently exists.

Today, laboratories are not required to bill the patient or responsible third-party payer for testing. As a result, physicians often request that they be billed for the testing that they order for their non-Medicare patients. The physician can then mark up this testing, often by a significant amount, when he bills the patient or insurer. This system can lead to increased testing because it gives the physician the ability to profit from his own test ordering, just as is the case with self-referral.

Because of the concerns raised by this practice, the Federal Government has prohibited it in the case of Medicare. The Medicare law requires the laboratory that performs the testing to bill the program directly.

Enactment of direct billing would have several important benefits. Most significantly, it would result in reduced utilization of laboratory testing and lower costs as found in a recent study conducted by the Center for Health Policy Studies. The Center compared the experience of Medicare and Blue Cross and Blue Shield plans in direct billing and nondirect billing States. The Center's report, which we have previously provided to you, found that laboratory prices and utilization were dramatically higher in nondirect billing States than in States that require direct billing.

The report also concluded that if a national direct billing law were enacted, annual savings in health care expenditures of between \$2.4 and \$3.2 billion could be achieved as a result of reduced utilization and lower prices. This translates into a saving of between \$12 and \$16 billion over the next 5 years.

Along with the extension of direct billing to all payers, ACLA's plan also calls for the establishment of payment caps on laboratory reimbursement from private payers, similar to the methodology that currently exists under Medicare. ACLA's proposal calls for these caps to be set at the statutorily defined Medicare fee schedule medians. Enactment of such a provision would substantially lower reimbursement in the private sector.

Further, the combination of direct billing and fee caps would ensure that the benefits of price and service competition are enjoyed by the ultimate payer, be that the patient or his insurer.

While it is impossible to calculate precisely how much such a provision would save, as competition could ultimately drive prices below this cap, ACLA expects that these savings would be substantial. The adoption of both of these measures together is a necessary predicate to the creation of a cost-conscious and efficient system.

Let me now turn to our second goal: ensured access to high-quality laboratory testing for all who need it. ACLA continues its long-held support for the goals of CLIA 88 and opposes any wholesale rollback of the law's safeguards.

Further, we urge that proposals for Medicare competitive bidding of laboratory services be carefully considered before adoption. Competitive bidding could have a significant and deleterious impact on both the quality and availability of laboratory testing. Similarly, we oppose the reimposition of coinsurance for Medicare beneficiaries because it would add an additional layer of paperwork to the current system, thereby undermining efforts to simplify it and would, in effect, impose an additional reimbursement cut on laboratories, threatening both quality and access.

With regard to our third goal, simplification, the ACLA plan would establish a process to clarify the rules covering certain types of laboratory tests and it would require that the current Medicare system which unnecessarily relies on 33 different carriers, each of which has its own rules and procedures, be streamlined and centralized.

As always, we are honored to have been here with you today. We look forward to working with you over the coming months on these

very important issues. We would be happy to answer your questions.

Thank you.

Chairman STARK. Thank you very much.

[The prepared statement follows:]



1919 Pennsylvania Ave., Suite 800, Washington, D.C. 20006/(202) 887-1400

STATEMENT OF THE AMERICAN CLINICAL LABORATORY ASSOCIATION REGARDING HEALTH CARE REFORM

October 22, 1993

The American Clinical Laboratory Association ("ACLA") is pleased to have this opportunity to comment on health care reform and its impact on the laboratory industry. ACLA is a trade association of federally regulated, independent clinical laboratories and represents national, regional and local laboratories located throughout the United States. All ACLA members will be significantly affected by whatever form health care reform ultimately takes.

Laboratory testing is an important, cost-effective and life-saving health care tool, which permits the early detection and treatment of a variety of diseases and conditions. Just a few examples illustrate its importance. Testing for cholesterol and related measurements for HDL and LDL help reduce the risk of heart disease. Pap smear screening has lead to significant reductions in deaths from cervical cancer. A simple screening test given to newborn babies detects PKU, a metabolic disorder that is treatable if caught early, but which can lead to retardation if left undiscovered. Other tests are routinely used to monitor the effectiveness of medication given to treat cancer and other serious diseases. In short, the early diagnosis and effective treatment permitted by appropriate testing ultimately enhances health, saves lives and reduces costs.

If these important diagnostic services are to be available to all who need them, reform of the system in which clinical laboratories operate is urgently needed. Indeed, ACLA has frequently come before this Subcommittee and urged the enactment of legislation that would bring about significant structural reform of the manner in which laboratory testing is delivered. Earlier this year, in March 1993, ACLA adopted its own health reform plan, which it presented to this Subcommittee during its consideration of OBRA '93.

In crafting our reform plan for laboratories, ACLA was guided by three overriding principles. First, such a plan should promote a more cost-conscious and efficient health care system. Second, it should ensure that all patients have access to high quality laboratory testing. Third, it should simplify the rules and procedures that govern the system.

The plan that ACLA drafted in March promotes all three goals. First, it would promote a more efficient system by eliminating those features that lead to overutilization of, and excessive prices for, laboratory testing. It would also end wasteful cost-shifting and impose meaningful cost-containment controls.

Second, ACLA's plan would ensure access to high quality laboratory testing for all those who need it. ACLA continues its long-held support for the goals of CLIA'88, and opposes any wholesale rollback of the law's safeguards. Further, we urge that proposals for Medicare competitive bidding of laboratory services, as suggested in the Administration's draft health care reform plan, be carefully considered before enacted, as they could have a significant, and deleterious, impact on the quality of laboratory testing. Similarly, we oppose the reinstitution of coinsurance for Medicare beneficiaries, because it would add an additional layer of paperwork to the current system, thereby undermining efforts to simplify it, and would, in effect, impose an additional cut on reimbursement to laboratories, threatening both quality and access.

Third, the ACLA plan would simplify the system by establishing a process to clarify the rules covering certain types of laboratory tests. And, it would require that the current Medicare

system, which unnecessarily relies on over 50 different carriers, all with their own rules and procedures, be streamlined and centralized.

ACLA's plan is a comprehensive program and will only achieve its goals if all of its components are adopted. In our testimony today, we would like to explain why reform of the industry is so urgently needed and how our proposal will help achieve the goals set out above.

A. PROMOTE A COST-CONSCIOUS AND EFFICIENT SYSTEM

In encouraging cost-consciousness and efficiency in the laboratory industry, ACLA would rely on the rules that this Subcommittee has already developed to reduce laboratory utilization and costs in the Medicare program. Several of these provisions, including a direct billing mandate and a system of payment caps, have worked well for Medicare and should be extended to other payors. In our view, a primary reason that the system is in need of reform is that these safeguards have only been applied to Medicare rather than to all payors.

1. Extension of Direct Billing Mandate to All Payors

The centerpiece of the ACLA plan is the enactment of a federal law mandating direct billing of laboratory services; *i.e.*, a requirement that the laboratory that performs the testing bill the patient or insurer for those services. This provision would simplify the structure of the industry and lead to a more rational, and efficient, market for laboratory services. Direct billing is required by H.R. 200, which Chairman Stark introduced earlier this year, and by S.337, which Senators Jeff Bingaman and Howard Metzenbaum sponsored.

Enactment of such a requirement would promote a more cost-conscious and efficient system for delivery of testing services than currently exists. Today, laboratories are not required to bill the patient or responsible third-party payor for testing. As a result, physicians often request that they be billed for the testing that they order for their non-Medicare patients. The physician can then mark up this testing, often by a significant amount, when he bills the patient or the appropriate third-party payor. This system can lead to increased testing because it gives the physician the ability to profit from his own test ordering, just as in the case of self-referral.

Because of the concerns raised by this practice, the federal government has prohibited it in the case of Medicare. The Medicare law requires the laboratory that performs the testing to bill the Program directly in most cases. The laboratory is prohibited from billing the physician that ordered the services. Thus, enactment of direct billing would simply extend the benefits of the Medicare rule to private payors and patients.

Enactment of direct billing would have several important benefits. Most significantly, it would result in reduced utilization of laboratory testing and lower costs as found in a recent study conducted by the Center for Health Policy Studies ("CHPS"). CHPS compared the experience of Medicare and Blue Cross/Blue Shield plans in direct billing and non-direct billing states. The CHPS report, which we have previously supplied to Members of the Subcommittee, found that laboratory prices and utilization were dramatically higher in non-direct billing states than in states that require direct billing. Among the study's findings were the following:

- Charges for laboratory services were 8.4 to 9.6% higher in non-direct billing states than in direct billing states.
- Laboratory utilization per enrollee was higher in non-direct billing states than in direct billing states. For tests reimbursed by Medicare, utilization was 6.5% higher and for tests reimbursed by private payors--where incentives for overutilization are greatest--it was 28.3% higher.
- Laboratory charges per enrollee under private health insurance programs, a measurement that takes into account both utilization and price differences, were 40.6% higher in non-direct billing states.

The report concludes that if a national direct billing law were enacted, annual savings in health care expenditures of between \$2.4 and \$3.2 billion could be achieved, as a result of

reduced utilization and lower prices. This translates into savings of between \$12 and \$16 billion over the next five years.

It is particularly appropriate that we should come before this Subcommittee today to discuss direct billing. This Subcommittee has always recognized the need to eliminate incentives that increase the use of laboratory testing. This Subcommittee led the fight to eliminate the practice of self-referral in the clinical laboratory industry because of its effect on utilization. ACLA supported that effort, and supports efforts to expand the prohibition beyond Medicare and Medicaid testing. The enactment of direct billing would complete that effort by eliminating another practice that provides an incentive for increased use of laboratory testing.

2. Reduce Cost-Shifting Through Enactment of Appropriate Cost Containment Measures Applicable to All

Along with the extension of direct billing to all payors, ACLA's plan also calls for the establishment of payment caps on laboratory reimbursement from private payors, similar to the methodology that currently exists under Medicare. ACLA's proposal calls for these caps to be set at the actual median of the Medicare fee schedules, as defined in Section 1833(h) of the Social Security Act.

Enactment of such a provision would substantially lower reimbursement in the private sector. Further, the combination of direct billing and fee caps would further ensure that the benefits of price and service competition are enjoyed by the ultimate payor, either the patient or insurer. While it is impossible to calculate precisely how much such a provision would save, as competition could ultimately drive prices below this cap, ACLA expects the savings would be substantial.

The adoption of both of these measures together is a necessary predicate to the creation of a cost-conscious and efficient system.

B. PROTECT THE QUALITY OF CLINICAL LABORATORY TESTING

The second goal promoted by ACLA's health care reform plan is to protect and enhance the quality of laboratory testing. Congress has already taken the most important step towards ensuring quality, by enacting the Clinical Laboratory Improvement Amendments of 1988. This law required for the first time that all laboratories, regardless of site, would be subject to federal jurisdiction and assured that they would comply with appropriate, minimal quality assurance rules. Prior to the enactment of CLIA, the vast majority of laboratories were unregulated by federal or state law. Hearings held at the time demonstrated that unregulated laboratories often failed to hire the most qualified personnel, follow quality control procedures, or participate in proficiency testing. CLIA was passed to correct these problems. As a result, ACLA supports the implementation of CLIA and must oppose any substantial weakening of its standards.

ACLA is also concerned about other proposals that could have an adverse impact on laboratory quality. Proposals for Medicare competitive bidding to procure laboratory testing services, as suggested in the Administration's September 7, 1993 draft health care plan, should be studied very carefully before they are enacted. The reference in the plan is brief and vaguely described; thus, it is difficult to comment on with any specificity. However, based on the models that have been discussed or used in the past, such a plan could threaten the quality of laboratory services and beneficiaries' access to these services. In any event, the details of the plan should be obtained and carefully scrutinized before such a proposal is seriously considered.

Finally, ACLA must object to the reimposition of coinsurance for laboratory testing provided to Medicare beneficiaries. This requirement was eliminated by Congress in 1984, with the support of HCFA and the laboratory industry, because the costs of billing for these coinsurance payments—which usually were just a few dollars—often exceeded the amount collected. Furthermore, when laboratories billed for the coinsurance, they often had to write off from 20 to 50 percent of the Medicare coinsurance amounts as uncollectable. Because of the costs of collection and the amount of bad debt associated with coinsurance, its reinstatement would single out laboratories for an additional cut in reimbursement of approximately 15 percent. A reduction of that size, coupled with the Medicare cuts imposed on laboratories by OBRA'93 and previous budget laws, would negatively affect both the quality of, and access to, laboratory

services. In addition, the reinstitution of coinsurance would add an additional layer of paperwork to the system at a time when we are all trying to simplify it and would of course impose additional cost burdens on Medicare beneficiaries.

C. PROMOTE SIMPLIFICATION

The third goal of the ACLA plan is to promote simplification of the current system. The ACLA plan has two points to promote this goal in the laboratory industry: clarification of rules relating to profiles and administrative simplification.

1. Clarify the Rules Relating to Test Profiles

"Test profiles" are groups of related tests that are often ordered together. For example, a physician ordering tests for a patient with liver disease may order a "hepatic profile," a group of tests used for patients known or suspected to have this condition. While profiles are a necessary and valuable tool, the rules governing their ordering and billing have long been unclear.

Because of confusion in this area, ACLA has adopted guidelines, which we would be happy to share with the Members, to help ensure that physicians ordering profiles understand what they are ordering and what the financial consequences of their test-ordering decisions are likely to be. Even more needs to be done in this area, however. Currently, there is no uniform set of rules concerning what may be included in a particular profile, a circumstance which adds to the confusion. Therefore, ACLA's plan calls for the establishment of a process to govern the development and modification of standardized profiles with established test components. ACLA would be pleased to work with the Department of Health and Human Services and various medical societies in developing such a list.

2. Promote Administrative Simplification

Today, at least 33 different Medicare carriers have jurisdiction over laboratories providing testing to Medicare beneficiaries. Because laboratories often have testing facilities in more than one state, several different carriers, each with its own procedures and policies, usually have jurisdiction over a laboratory's operation. This system leads to confusion and unnecessary effort for all parties. As a result, the current system should be changed, so that laboratories could submit Medicare claims to a single carrier.

Further, the system should be clarified so that all providers understand what medical and insurance information must be obtained from each patient. This change would be especially important for laboratories, because they often do not have direct contact with the patient and have difficulty obtaining the required information if it is not provided initially by the physician.

Conclusion

ACLA is pleased to have this opportunity to testify before the Subcommittee today. We look forward to working with you in achieving the three goals of promoting a more efficient and cost-conscious system, protecting the quality of laboratory testing, and simplifying the system. We would be happy to answer any questions.

Chairman STARK. Dr. Harris, you haven't had the joy in your group of getting very involved with Medicare.

Dr. HARRIS. That is right.

Chairman STARK. But let's assume for a minute that in whatever program we work out, that we will certainly start with children's dental care and preventive care and, over time, phase in some agreed-to dental services. And you have heard the discussions today about a variety of ways for reimbursement. What would be the—in terms of the reimbursement programs you are familiar with, and I suppose your choice would be capitation or—

Dr. HARRIS. No, no, sir.

Chairman STARK. I say, your alternatives.

Dr. HARRIS. Alternatives, I am sorry. You said choice.

Chairman STARK [continuing]. Would be capitation or a fee-for-service, which I think is almost universal. Would you be comfortable with—well, let me put it another way, the same way I asked the previous panel.

To your knowledge, which system that you are aware of, whether it is a dental or whatever system, is in your opinion the least objectionable if you have to have an imposed reimbursement structure?

Dr. HARRIS. Well, as discussed in the testimony that we just gave and the written testimony we presented to you, we have—with fits and starts and battles and everything with the third parties, we have designed a system that really does work, and we feel like the fee-for-service system we have, which involves things like copays, deductibles, annual limits, very predictable prepayment system, it does pay for prevention first, which, of course, I think has certainly turned around the disease patterns of this country when it comes to dental disease—that and the fluoridation put together.

Chairman STARK. The issue is, in any system, if the Federal Government directly or indirectly is going to pay for this, or indeed control the payment, there are going to be some controls; and that means, as you have heard us discuss with the physicians, somebody is going to have to negotiate with you. And I guess I am saying that the only plan that comes to mind, I guess, is Delta; but I am sure across the country there are other reimbursements. Blue Cross has an option. They pay something. I have never figured out exactly what they do pay.

I am just asking you from the standpoint of your association, is there any one particular—mention the brand name.

Dr. HARRIS. In any of those fee-for-service plans, you mean?

Chairman STARK. Yes, that you are more comfortable with than others or less uncomfortable with.

Dr. HARRIS. I think I—you know, each of those has their day. The main thing is, we are looking—or we feel that with—the fee-for-service method is the best method.

Now, who administers that—certainly the Delta has done well, and we have worked very well with them; but the major carriers we have worked very well with also as time goes by.

Chairman STARK. Would one system be preferable?

Dr. HARRIS. They are all very similar. As a matter of fact, we have a universal claim form. We have universal—

Chairman STARK. You already have that?

Dr. HARRIS. Yes, sir, we have all those things in our system already.

Chairman STARK. And your fees are generally the same for all providers, for the most part?

Dr. HARRIS. They all have a profile on each practitioner; but, yes, they are in line certainly.

Chairman STARK. Thank you.

Dr. HARRIS. Yes, sir.

Chairman STARK. Mr. Burch, I would have to ask you the same question for physical therapists. For those who are in private practice, is there a—any particular reimbursement structure that comes to mind to you, whether it is Medicare or any of the others that is less objectionable than the others?

Mr. BURCH. Obviously, I feel that—being a practitioner, that a fee-for-service type of arrangement is the best. But, obviously, we are going to have some changes. I would like to be able to negotiate a reasonable fee and I am speaking for my company. We don't mind that negotiation having some risk sharing in there so we can control the utilization. We can assure the quality of our treatments so they are cost effective. We know what the outcomes are going to be.

Chairman STARK. Are you talking not only on a capitated basis, but also on a rehabilitation program where you will take the risk of treating that patient for as long as it takes? Say, as an accident recovery or something like that, to—

Mr. BURCH. Chairman Stark, that is correct. But in all of these, there is built in the dread word "capitation," because I can't take just the low risk from your particular company.

Chairman STARK. No, but Kaiser in my area hires physical therapists, but on the same basis they hire doctors. Everybody there is on a salary; and I would presume in that kind of an area, your members have no objection. They work not for a physician, but for Kaiser. Certainly if it was working they can't object to it, and—

Mr. BURCH. In our particular region?

Chairman STARK. And in my area, you know, the private practice can't—they aren't going to get any Kaiser patients anyway. That is the reality of people who join HMOs. So I am just trying to figure out whether there was a system or a payment structure that worked better, in general, for all of you.

Mr. BURCH. Most of the major insurers cover us adequately. I am speaking for us in Maryland. Our problem is, when they come in with arbitrary cuts retroactively to say that this care was not needed, when your documentation says that it was, we think that this is a Draconian approach that should be stopped. If the documentation indicates that the care was needed, it should be paid for and that is what we are talking about in risk-sharing when we write a contract.

Chairman STARK. We have heard some testimony that keeps coming up. People are grumbling about CLIA; and as clear as I can determine, it goes something like this. There is this dedicated, hard-working, rural physician 500 miles from anyplace and because of CLIA, if there is an immediate urinalysis or blood workup that is necessary, it is impossible for this doctor to do it.

Now, I understand—I thought I understood the need for CLIA was to improve quality in test results; and they seem to stipulate that, in the more complex tests, that is true. So I gather the objection is in very simple tests.

I also suspect that the physician isn't actually doing those tests him- or herself anyway, that they have got a technician doing it.

Is there any objection, for certain basic and simple tests, to having a physician who performs the actual test being exempted from CLIA?

Ms. FOSTER. Mr. Chairman, let me answer that question with a personal—a little piece of personal history.

First, let me say, no, of course we have no objection to a physician actually performing simple tests themselves; but I had an experience that may shed some light on your question. I was asked by my son's pediatrician to run routine urinalysis on him when he had a kidney infection. Our doctor gave me a box full of urine dipsticks and said, use this and call me and tell me what the color is.

Now, I am a lawyer so I have an advanced degree, but I don't have a clue, not a clue, about how to conduct lab tests..

So I took the little box home and I read the instructions, which proved to be quite incomplete, and I will tell you that I conducted these tests completely wrong. Apparently you are supposed to wait a certain period of time, after dipping the strip in the urine and removing it before checking the strips color, but I misconstrued the instructions.

Chairman STARK. Have you ever tried to assemble a gas barbecue?

Ms. FOSTER. No, and we are all very lucky.

Chairman STARK. I think that is the level at which we ought to test your ability.

Ms. FOSTER. I think we are all very fortunate that I have not been asked to assemble such an item in that I assume there is a great deal of danger involved in dealing with gas.

All I can tell you is that I was unable to do these tests correctly. The dipstick did change color. I did try and measure it against the color spectrum they gave me. The colors bore no relationship to the spectrum that was on the container.

I was a very poor lab technician. The policy problem here is that we don't know who in these facilities is actually doing the tests.

One of the things that was disturbing about the record which was developed during debate on CLIA 88 is that there were high school students doing these tests. Now, if I, with a juris doctor degree couldn't understand what these instructions said assume that a high school student might have similar difficulty.

One would hope that a doctor would train a high school student or any person without formal training about how to properly conduct these tests, but I think there are real problems with knowing who is doing the testing, and even in the simplest cases, knowing that they are doing it correctly and that the materials they are using are still effective because they become stale and ineffective after a period of time.

Chairman STARK. What is the objection to CLIA: they are not able to bill enough, or there is more paperwork, the paperwork required to make sure they do it right?

Ms. FOSTER. With regard to the urinalysis example I gave, that is currently a waived test, so it can be done in any laboratory without any regulatory control under CLIA. All you have to do is register.

Chairman STARK. Are there other tests like that?

Ms. FOSTER. Yes, there are a series of tests which have been given waived status by the Health Care Financing Administration pursuant to the legislation.

Chairman STARK. Well, as I say, it is a puzzle to me, and I am always curious as to what brings out these complaints. I wish that I knew more for each of you because I know your interests will be far more specific about what exactly is in the benefit package and what isn't and because I don't know either, I am waiting for Ira Magaziner and the White House team to give us the final word, and we will know next week.

So I am really at a loss to inquire as to whether the benefits will be ones that you think we should have, and whether the system for determining how you, or your constituents, will fit into this package will work yet.

We have some much broader issues that we know for physicians, in general. There is an indication that dentistry should be covered, and I gather we will start with pediatric dentistry and work our way up the scale.

Dr. HARRIS. If I may just put this in, Mr. Stark. That is part of our concern. We feel like we are treating 60, 65 percent of our population on a routine basis and doing a very fine job of it at this point. There is a segment of our population that we just can't cover. Medicaid programs for dentistry are horrible. In most instances, they are abject failures. So as a result of that, whatever is being done for those folks is being done really on a basis of donated charity care, that sort of thing.

And yet we are seeing a plan in the administration plan to cover all children 18 and under, but what we think ought to be taken care of are those people that we are not able to take care of now because there are no funds to take care of them.

So we would like to see it, instead being done on age, be done on a need basis initially; and that is what I would hope we could do somehow.

Chairman STARK. Well, as I say, I would like to see the benefits be as generous as we can make them. I am afraid that that will never be the case. Regardless of what service or product you might provide, we are going to be driven in this whole issue by budget considerations.

Dr. HARRIS. I understand.

Chairman STARK. So I guess what I am saying is that we will be back with each of you discussing in more detail your feelings about the benefits. You may suggest, and hopefully you will, that if the level of benefits or the type of benefits provided—you might say to me that we could provide for the same dollars a better set of benefits. That would be wonderful news, because that is easier

for us to do. When you say we need more money, that is often tougher.

So we will be counting on your helping us in the future; and for dentistry, in particular—this is a new area for us, not so much for the committees who deal with Medicaid, but we have precious little experience with you on the Medicare side, and although we have been acquainted, we haven't worked together, and I know you will find it a joyous experience.

Dr. HARRIS. We look forward to it, sir.

Chairman STARK. You can ask other providers for recommendations, but I want to thank you for—I had hoped at this particular time that we would have more details, and you perhaps have the Damnation of the Fates of being early in the process here, but we will give you a chance to get back when you do have before you more specific details; and we will get more detailed comments from you at that time.

I appreciate your bearing with us on this and look forward to discussing this with you in more detail. Thank you.

[Whereupon, at 1:37 p.m., the hearing was adjourned.]



BOSTON PUBLIC LIBRARY



3 9999 05983 469 5

ISBN 0-16-046163-4



9 780160 461637



90000

